Unannounced Medicines Management Inspection Report
22 March 2018

Iveagh House Private Nursing Home

Type of Service: Nursing Home
Address: 62 Castlewellan Road, Banbridge, BT32 4JD
Tel No: 028 4062 8055
Inspector: Judith Taylor

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home which is registered to provide nursing care for up to 33 persons.

3.0 Service details

Organisation/Registered Provider: Harold Mitchell (Belfast) Ltd **Responsible Individual:** Mr Harold Leslie Mitchell	**Registered Manager:** Mrs Patricia Purvis
Person in charge at the time of inspection: Mrs Patricia Purvis	**Date manager registered:** 23 March 2015
Categories of care: Nursing Homes (NH) I – Old age not falling within any other category	**Number of registered places:** 33

4.0 Inspection summary

An unannounced inspection took place on 22 March 2018 from 10.20 to 15.00.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

The inspection assessed progress with any areas for improvement identified since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to administration of medicines, the completion of most medicine records, the storage of medicines and the management of controlled drugs.

One area requiring improvement was identified in relation to personal medication records.

Patients spoke positively about the management of their medicines and the care provided by staff and management. They were noted to relaxed and comfortable in their surroundings.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Patricia Purvis, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection

No further actions were required to be taken following the most recent inspection on 7 November 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection

A poster was displayed to inform visitors to the home that an inspection was being conducted.

During the inspection we met with two patients, two registered nurses and the registered manager.

Ten questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- medicines storage temperatures

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 7 November 2017

The most recent inspection of the home was an unannounced care inspection. There were no areas for improvement identified as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 1 November 2016

There were no areas for improvement identified as a result of the last medicines management inspection.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed that medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for registered nurses and for care staff who had been delegated medicine related tasks e.g. swallowing difficulty and the administration of external preparations. Medicines management training was provided on an annual basis. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training on the management of syringe drivers and enteral feeding had also been completed in the last year.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training was completed each year.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines, and also advised of the occasional difficulties in obtaining medicines. Advice was given. Antibiotics and newly prescribed medicines had been received into the home without delay. It was agreed that the storage of prescriptions would be reviewed to ensure these were stored securely.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Medicine refrigerators and oxygen equipment were checked at regular intervals. Staff were reminded that the refrigerator thermometer should be reset on a daily basis.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and controlled drugs.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The majority of medicines were supplied in a 28 day monitored dosage system (MDS). For some medicines which were not supplied in the MDS, but were prescribed on a daily basis, running stock balances were maintained. This good practice was acknowledged. The audit outcomes from a sample of these medicines indicated they had been administered as prescribed.

There was evidence that time critical medicines had been administered at the correct time. In relation to weekly medicines, not all of the records indicated the day of the week the medicine was due and it was noted that one medicine had been administered one day late and this finding was discussed with the registered manager. The registered manager agreed to ensure that the day of administration was clearly marked on the personal medication records and medication administration records.

The management of distressed reactions, swallowing difficulty and pain were reviewed. The relevant information was recorded in the patient's care plans and medicine records.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the patient's health were reported to the prescriber.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for transdermal patches. However, it was found that some of the personal medication records were not up to date and an area for improvement was identified. For two patients, some further details were required and this was being addressed by staff and management during the inspection.

Following discussion with the registered manager and staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to patients' healthcare needs.

Practices for the management of medicines were audited on a regular basis by the staff and management. The registered manager also advised that a specific audit regarding delegated tasks was completed on a monthly basis. A quarterly audit was completed by the community pharmacist.

Areas of good practice

There were examples of good practice in relation to the completion of most medicine records, care planning and the administration of medicines.

Areas for improvement

The necessary arrangements should be made to ensure that personal medication records are checked on a regular basis to ensure accuracy.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The administration of medicines to patients was completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible. The registered nurse explained the medicine and encouraged the patients to take their medicines.

Throughout the inspection, it was found that there were good relationships between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity. It was clear from discussion and observation of staff, that they were familiar with the patients' likes and dislikes. Patients were noted to be relaxed and comfortable in the surroundings.

We met with two patients, who expressed their satisfaction with the care, the staff and the registered manager. They advised that they were administered their medicines on time and any requests e.g. for pain relief, were adhered to. Comments included:

- "They (staff) look after me"
- "Everybody is well cared for"
- "I can request what I need"
- "I am happy here"

Of the questionnaires which were left in the home to obtain feedback from patients and their representatives, none had been returned within the specified time frame (two weeks).

Areas of good practice

Staff listened to patients and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Written policies and procedures for the management of medicines were in place. Management advised that these had been reviewed in 2016. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

The governance processes for medicines management were examined. In addition to the ongoing medicine audits, the registered manager received a daily report from staff and advised that any identified issues were addressed in a timely manner.

There were effective communications systems in the home to ensure that all staff were kept up to date. As well as verbal shift handover, a printed handover sheet was also used to inform staff of patients with specific medical conditions and any updates.

Following discussion with the registered manager and staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated through team meetings, supervision or individually with staff. They advised that management were open and approachable and willing to listen; and stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

No online staff questionnaires had been completed within the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Patricia Purvis, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time	The registered person shall make the necessary arrangements to ensure that personal medication records are kept up to date at all times. Ref: 6.5
To be completed by: 23 April 2018	**Response by registered person detailing the actions taken:** I have addressed this issue and have delegated staff to to check files on a weekly basis.

Please ensure this document is completed in full and returned via the Web Portal

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