

# Unannounced Medicines Management Inspection Report 13 December 2017



## Lisnisky

Type of Service: Nursing Home

Address: 16 Lisnisky Lane, Portadown, Craigavon, BT63 5RB

Tel No: 028 3833 9153

Inspector: Catherine Glover

[www.rqia.org.uk](http://www.rqia.org.uk)

Assurance, Challenge and Improvement in Health and Social Care

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 with 63 beds that provides care for patients with a range of needs as detailed in Section 3.0.

### 3.0 Service details

<b>Organisation/Registered Provider:</b> Four Seasons Healthcare  <b>Responsible Individual:</b> Dr Maureen Claire Royston	<b>Registered Manager:</b> See below
<b>Person in charge at the time of inspection:</b> Mrs Linda Graham	<b>Date manager registered:</b> Mrs Linda Graham – acting, no application required
<b>Categories of care:</b> Nursing Homes (NH) DE – Dementia I – Old age not falling within any other category TI – Terminally ill.  Residential (RC): I – Old age not falling within any other category. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. PH – Physical disability other than sensory impairment. LD(E) – Learning disability – over 65 years.	<b>Number of registered places:</b> 63 comprising:  47 Nursing, 16 Residential  Of the 47 patients accommodated in the nursing category there shall be a maximum of 14 assessed as DE. The home is approved to provide care on a day basis only to nine persons.

### 4.0 Inspection summary

An unannounced inspection took place on 13 December 2017 from 10:30 to 14:00.

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.

The term 'patients' is used to describe those living in Lisnisky which provides both nursing and residential care.

Evidence of good practice was found in relation to medicines administration, storage, record keeping and the management of controlled drugs.

No areas requiring improvement were identified.

Patients said that the home and staff were “very good”.

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
<b>Total number of areas for improvement</b>	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Linda Graham, Manager, as part of the inspection process and can be found in the main body of the report.

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 21 June 2017.

#### 5.0 How we inspect

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

- 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

During the inspection we met with four patients, two registered nurses and the 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
- training records
- 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 21 June 2017

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

### 6.2 Review of areas for improvement from the last medicines management inspection dated 24 October 2016

There were no areas for improvement made 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.**

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 senior care assistants who had responsibility for medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was planned for the new year.

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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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.

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

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

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. The use of separate administration charts was acknowledged.

Appropriate arrangements were in place for administering medicines in disguised form.

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.

### 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
<b>Total number of areas for improvement</b>	0	0

### 6.5 Is care effective?

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

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly or monthly medicines were due.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff advised that most of the patients could verbalise any pain, and a pain tool was used as needed. A care plan was maintained.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Each administration was recorded and care plans and speech and language assessment reports were in place.



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.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included extra records for the administration of transdermal patches and antibiotics.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the manager and staff, it was evident that other healthcare professionals are contacted when required to meet the needs of patients.

### **Areas of good practice**

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

### **Areas for improvement**

No areas for improvement were identified during the inspection.

	<b>Regulations</b>	<b>Standards</b>
<b>Total number of areas for improvement</b>	0	0

### **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.**

During the inspection patients were observed to be engaged in arts and crafts with the staff. They were making festive jewellery and were enjoying the activities led by the staff. There was a warm and welcoming atmosphere in the home and visitors were greeted by name by staff.

The administration of medicines to patients had been completed prior to the commencement of this inspection and was not observed. Registered nurses were knowledgeable regarding patients' preferences with respect to their medicines.

None of the questionnaires were returned within the timeframe for inclusion in this report..

We spoke to one recently admitted patient who said that the care in the home was very good and had high praise for the staff in the home.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

### Areas of good practice

Staff listened to patients and relatives and took account of their views.

### Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
<b>Total number of areas for improvement</b>	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. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

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.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the manager and registered nurses, 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 there were good working relationships in the home.

### 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
<b>Total number of areas for improvement</b>	0	0

**7.0 Quality improvement plan**

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.



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