

Unannounced Medicines Management Inspection Report 19 December 2017



Faith House

Type of Service: Nursing Home
Address: 25 Orpen Park, Belfast, BT10 0BN
Tel No: 028 9061 2318
Inspector: Rachel Lloyd

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 registered to provide nursing and residential care for up to 67 persons as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Board of Trustees – Faith House Responsible Individual: Mr Mervyn Wishart	Registered Manager: Mrs Jane Moore
Person in charge at the time of inspection: Mrs Wendy Grudgings (Deputy Manager)	Date manager registered: 9 January 2015
Categories of care: Nursing Homes (NH): I – Old age not falling within any other category PH – Physical disability other than sensory impairment TI – Terminally ill Residential Care (RC): I – Old age not falling within any other category	Number of registered places: 67 A maximum of 36 patients in categories NH-I, NH-PH and NH-TI and a maximum of 31 residents in category RC-I.

4.0 Inspection summary

An unannounced inspection took place on 19 December 2017 from 09.40 to 14.10.

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 term ‘patients’ is used to describe those living in Faith House which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified during and 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 the administration of medicines, the majority of medicine records, care planning, communication with various healthcare professionals, working relationships within the home and the management of the ordering and supply of medicines.

Areas requiring improvement were identified in relation to updates on medication administration records and the management of insulin pen devices.

The patients spoken to advised that they had no concerns in relation to the management of their medicines and they spoke very positively about their care. Their comments included:

“The staff are great” and “If you need anything, it happens straight away”.

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	1	*1

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Wendy Grudgings, Deputy 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 and premises inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 23 August 2017. Enforcement action did not result from the findings of this inspection.

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 - prior to the inspection, it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

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

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
- care plans
- training records
- medicines storage temperatures
- policy and procedure documents

We met with two patients and one visitor, two registered nurses, two senior care assistants and the deputy 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.

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

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 23 August 2017

The most recent inspection of the home was an announced variation to registration inspection by both a care inspector and an estates inspector. The completed QIP will be returned and will be assessed by the estates inspector. This QIP will be validated by the estates inspector at the next premises inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 7 June 2016

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		Validation of compliance
Area for improvement 1 Ref: Standard 29 Stated: First time	The registered person should ensure that handwritten entries on medication administration records are checked and signed by two trained members of staff.	Not met
	Action taken as confirmed during the inspection: This was not evidenced in the majority of examples examined. Staff were aware that this should take place to ensure accuracy in transcription.	
	This area for improvement was stated for a second time.	

Area for improvement 2 Ref: Standard 4 Stated: First time	The registered person should ensure that care plans are developed further for the management of pain and distressed reactions for individual patients.	Met
	Action taken as confirmed during the inspection: Care plans and records of administration were in place in each example examined and the reason for and outcome of administration were recorded on most occasions.	

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 for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training had been provided on the management of medicines in 2017 and records had been maintained. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

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 procedures in place to ensure the safe management of medicines during a patient's admission to the home and discharge from the home.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses. However, handwritten additions to printed medication administration records had not been verified by two trained members of staff, to ensure accuracy. An area for improvement under standards, identified at the last medicines management inspection, was stated for a second time.

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

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. Medicine refrigerators and oxygen equipment were checked at regular intervals. There were mostly satisfactory systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. However, of the two insulin pen devices in use, one was not marked with the date of opening and the other had been in use for nine days past the expiry date, of 28 days after opening. An area for improvement under regulations was identified.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, supervision and appraisal, the management of medicines on admission, obtaining acute and new medicines promptly and the management of controlled drugs.

Areas for improvement

An area for improvement was identified in relation to ensuring that insulin pen devices, with a limited shelf-life after opening, are not used after expiry.

	Regulations	Standards
Total number of areas for improvement	1	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. Some minor discrepancies were highlighted to staff for their attention. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff as to when doses of weekly, monthly or three monthly medicines were due.

The management of distressed reactions, swallowing difficulty and pain were reviewed. The relevant information was recorded in the patient’s care plan, personal medication record and records of administration.

The deputy manager discussed and requested advice on plans to enhance food presentation, following a recent information day attended by staff, detailing the use of food thickeners in the presentation of food for patients prescribed a soft diet.

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. Most medicines were marked with the date of opening.

Practices for the management of medicines were audited throughout the month by the staff and management. In addition, audits were completed by the community pharmacist. Running stock balances were being maintained for several medicines, not contained within the monitored dosage system, to assist staff in monitoring their administration. This is good practice.

Following observation, discussion with the staff and examination of records, 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 found throughout the inspection in relation to record keeping, care planning, the administration of medicines, audit procedures and communication between patients, staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	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.

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.

Throughout the inspection, good relationships were observed between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity.

The home was decorated in a festive manner and during the morning a local primary school choir visited and sang Christmas carols, this was broadcast throughout the home. In the afternoon a number of visitors were in attendance for a festive carol programme involving patients and staff.

Patients spoken to at the inspection advised that they had no concerns in relation to the management of their medicines and that requests for medicines prescribed on a 'when required' basis were responded to promptly. They spoke very positively about their care.

Their comments included:

"The staff are great" and
 "If I ask for anything, it happens straight away" and "there are lots of activities, we are each provided with a weekly programme with a quiz on the back to keep the brain ticking over".

A visitor to the home commented that "The home is very good. The staff and food are of a high standard".

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.

Six of the questionnaires left in the home to facilitate feedback from patients and relatives were returned prior to the issue of this report. They all indicated that they were very satisfied with the management of their/their relative’s medicines.

Relatives’ commented included:

“The care in Faith House is of an excellent standard. My Mum is very contented there....the home as such a high standard of cleanliness. The carers/all staff are brilliant.”

“Everything is very good.”

“The staff are so kind and considerate treating my mother with an almost family experience.”

“The level of care is second to none. The staff are all exceptionally caring and compassionate and get to know the residents and personalise their care....Any opportunity to do more is proactive.”

Areas of good practice

There was evidence that staff listened to and valued patients and took account of their views. Good relationships were observed between staff and patients.

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; these had been reviewed in 2015. 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 satisfactory arrangements in place for the management of any medicine related incidents. Staff confirmed that they knew how to identify and report 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 registered nurses and senior care assistants, 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 stated that there were good working relationships and that management were open and approachable and willing to listen.

One of the areas for improvement identified at the last medicines management inspection had not been addressed effectively. To ensure that these are fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Part of the nursing home is currently in the process of being registered as a separate residential care home. The management of medicines is undertaken by trained and competent care staff. Staff were advised that when the registration process was complete, discontinued and out of date medicines from the residential unit should be returned directly to the community pharmacist for disposal.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, the management of medicine incidents and maintaining good working relationships. 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 Wendy Grudgings, Deputy 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 Nursing Homes Regulations (Northern Ireland) 2005

<p>Area for improvement 1</p> <p>Ref: Regulation 13(4)</p> <p>Stated: First time</p> <p>To be completed by: 19 January 2018</p>	<p>The registered person shall review procedures to ensure that insulin pen devices are marked with the date of opening and discarded after expiry according to the manufacturer's instructions.</p> <p>Ref: 6.4</p>
	<p>Response by registered person detailing the actions taken: All nursing staff have been informed of importance of ensuring date of opening on all insulin pens to ensure discarded after expiry date. This will be included in medication audits</p>

Action required to ensure compliance with The Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

<p>Area for improvement 1</p> <p>Ref: Standard 29</p> <p>Stated: Second time</p> <p>To be completed by: 19 January 2018</p>	<p>The registered person should ensure that handwritten entries on medication administration records are checked and signed by two trained members of staff.</p> <p>Ref: 6.2 & 6.4</p>
	<p>Response by registered person detailing the actions taken: All staff responsible for medications have been informed of importance of ensuring records are checked and signed by two staff when handwritten entries are made. Audits will be done to ensure compliance.</p>

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



The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Email info@rqia.org.uk
Web www.rqia.org.uk
📍 @RQIANews

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