Unannounced Medicines Management Inspection Report
12 October 2017

Nazareth House Care Village

Type of Service: Nursing Home
Address: 516 Ravenhill Road, Belfast, BT6 0BW
Tel No: 028 9069 0600
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 with 48 beds that provides care for patients living with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Poor Sisters of Nazareth **Responsible Individual:** Ms Jenny Hall	**Registered Manager:** Mrs Patricia McMullan
Person in charge at the time of inspection: Mrs Patricia McMullan	**Date manager registered:** 30 September 2008
Categories of care: Nursing Homes I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) – Physical disability other than sensory impairment – over 65 years TI – Terminally ill	**Number of registered places:** 48

4.0 Inspection summary

An unannounced inspection took place on 12 October 2017 from 10.00 to 15.30.

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.

Overall, there was evidence of good practice in relation to medicines management; this included staff training, administration of medicines, record keeping, management of new patient's medicines/medicines changes and the storage of medicines/controlled drugs.

Areas requiring improvement were identified in relation to care planning regarding the management of distressed reactions and the monitoring of fluid intake charts.

Patients and one relative were complimentary regarding the management of their medicines and the care provided in the home.

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	2

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Patricia McMullan, Registered Manager and Mrs Margaret Devine, 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 inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 22 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 reported to RQIA since the last medicines management inspection

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

During the inspection we met with three patients, one relative, four care staff, three registered nurses, the deputy manager and the registered manager.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

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 22 August 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 24 February 2017

There were no areas for improvement 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 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 was provided in the last year. This included the management of enteral feeding, syringe drivers, safeguarding and palliative care.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Antibiotics and newly prescribed medicines had been received into the home without delay. The storage of prescriptions was discussed. It was agreed that all acute prescriptions awaiting collection would be stored securely.

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; and to manage changes to prescribed medicines.

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

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. A discrepancy was noted in the stated stock balance and the actual stock balance of one ampoule of morphine.

This was investigated, including a review of other records and it was concluded that the staff had not recorded this administration in the controlled drug book. Therefore, there was no actual discrepancy and this was discussed with management. Staff also advised of the circumstances which may have caused this error in record keeping at that time. 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.

A small number of medicines were required to be crushed prior to administration. This was clearly recorded on the medicine label.

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 found throughout the inspection in relation to staff, training and competency assessment, the management of medicines on admission and the storage of medicines.

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.

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. A few discrepancies were noted and shared with staff and management. They provided assurances that these medicines would be closely monitored within the audit process.

There were satisfactory arrangements in place to alert staff of when time critical medicines must be administered, such as medicines prescribed for Parkinson's and also medicines which were prescribed at four day, weekly or three monthly intervals.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. The reason for and the outcome of administration were not always recorded. A care plan was not maintained for all patients prescribed these medicines. An area for improvement was identified.

The management of enteral feeding was reviewed. The enteral feed was recorded on the patients' personal medication record. Whilst it was acknowledged that separate charts were in use to record administration of the enteral feed and the flushes of water including those administered at times of medicines administration, some of the records were incomplete. An area for improvement was identified.

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 assessment 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.

When antibiotics were prescribed, a care plan was maintained. This is good practice.

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. They confirmed that most patients were generally compliant with their medicine regimes.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included double signatures for the writing and updating of personal medication records and medication administration records; and for the administration of warfarin.

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.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the administration of medicines, the standard of most medicine records and care plans. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

The management of distressed reactions should be reviewed to ensure that when these medicines are prescribed, a care plan is in place and the reason for and outcome of any administration is recorded.

A monitoring system should be developed to ensure that fluid intake charts are fully and accurately completed.

	Regulations	Standards
Total number of areas for improvement	0	2

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 observed during the inspection. The registered nurse administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to swallow each medicine. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

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 the staff were familiar with the patients' likes and dislikes.

Staff provided examples of when medicines were administered at a later time to facilitate the patients' preferences, as some patients liked to sleep longer in the morning. They confirmed that they were aware of and adhered to the prescribed time intervals between medicines.

The patients spoken to, advised that they had no concerns in relation to the management of their medicines, they preferred the registered nurses to administer their medicines and their requests for medicines prescribed on a "when required" basis were adhered to, e.g. pain relief. They were complimentary regarding staff and management.

Comments included:

"They are good staff."
"I am content and comfortable here."
"The food is good."
"I can get what I need."
"They do look after you."

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.

The relative we spoke with raised no concerns regarding the care provided in the home.

We met with staff throughout the inspection.

Comments included:

“I think it’s great here.”
“The support is good.”
“We are kept updated with our training.”
“It’s a good team of staff.”
“Some staff are better at listening/responding and are more approachable than others.”

This latter comment was shared with management during feedback for consideration.

Of the questionnaires which were left in the home to facilitate feedback from patients, their representatives and staff, one was returned from a patient, two from patient’s representatives and one from staff. The responses indicated that they were very satisfied/satisfied with all aspects of the care in relation to the management of medicines.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the staff listening to and taking account of the views of 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 were not examined in detail. 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 systems in place to manage any medicine related incidents. Staff confirmed that they knew how to identify and report incidents and advised of how incidents were shared with them to inform learning and change of practice, if necessary. 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 auditing arrangement for medicines was reviewed. A range of medicine audits were completed by the registered nurses and management, on a weekly and monthly basis. In addition an audit was completed by the community pharmacist throughout the year. A review of the audit records indicated that largely satisfactory outcomes had been achieved.

Management advised of the procedures followed when any areas were identified for improvement and provided details of where practice had changed. 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.

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 McMullan, Registered Manager and Mrs Margaret Devine, 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 QIP via 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 18 **Stated:** First time **To be completed by:** 12 November 2017	The registered person shall review the management of distressed reactions in relation to care plans and records of administration. Ref: 6.5
	Response by registered person detailing the actions taken: All residents who present with distressed reactions now have these included in their careplans and medication given is evaluated, and monitored closely and outcomes recorded.
Area for improvement 2 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 12 November 2017	The registered person shall develop a monitoring system to ensure that fluid intake charts in relation to enteral feeding are fully and accurately maintained. Ref: 6.5
	Response by registered person detailing the actions taken: Specific charts have now been implemented to accurately record all fluids given to residents with PEG feeds.

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

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