Unannounced Medicines Management Inspection Report
16 October 2018

Nazareth House Care Village

Type of Service: Nursing Home
Address: 516 Ravenhill Road, Belfast, BT6 0BW
Tel No: 028 9069 0600
Inspector: Rachel Lloyd

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 care for up to 60 patients. The nursing home is on the same site as a residential care home.

3.0 Service details

Organisation/Registered Provider: Nazareth House Care Village **Responsible Individual:** Mr John O'Mahoney (Registration pending)	**Registered Manager:** Mrs Patricia McMullan
Person in charge at the time of inspection: Mrs Margaret Devine (Deputy Manager)	**Date manager registered:** 30 September 2008
Categories of care: Nursing Homes (NH) 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:** 60

4.0 Inspection summary

An unannounced inspection took place on 16 October 2018 from 10.45 to 15.45.

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 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 medicines management, medicine records, medicine storage and the management of controlled drugs.

No areas for improvement were identified.

Patients were relaxed and comfortable in the home and good relationships with staff were evident. 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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Margaret Devine, Deputy 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 5 March 2018.

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 and one relative, five registered nurses including the deputy manager, and Chief Nursing Officer for Nazareth Care Ireland, Mr John Rafferty.

We provided the deputy manager with 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. 'Have we missed you?' cards were left in the foyer of the home to inform patients/their representatives of how to contact RQIA, to tell us of their experience of the quality of care provided. Flyers providing details of how to raise any concerns were also left in the home.

We asked the deputy manager to display a poster which invited staff to share their views and opinions 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
- care plans
- training records
- medicines storage temperatures

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 manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 5 March 2018

The most recent inspection of the home was an announced 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 12 October 2017

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 18

Stated: First time</td><td>The registered person shall review the management of distressed reactions in relation to care plans and records of administration.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The management of distressed reactions had been reviewed. Five patient records were examined. For three of these a patient specific care plan was in place. Care plans were put in place for the other two patients during the inspection. Reasons for the administration of ‘when required’ medicines and the outcome were usually recorded in the daily notes or on a separate administration chart. Nurses were reminded that this should take place on every occasion and that one system of recording this should be used consistently to facilitate review.

This was discussed and agreed and due to the actions taken and the assurances received this area for improvement was assessed as met.</td></tr>
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Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered person shall develop a monitoring system to ensure that fluid intake charts in relation to enteral feeding are fully and accurately maintained.	**Met**
	Action taken as confirmed during the inspection: The records for one patient were examined and fluid balance charts were maintained in a satisfactory manner.	

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. The impact of training was monitored through team meetings, supervision and annual appraisal. Refresher training in medicines management was provided in the last year. Competency assessments were completed annually. Specific training in Duodopa pumps and Apo-Go pumps for use in Parkinson's, syringe drivers and palliative care had been provided 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.

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.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records (MARs) were updated by two members of staff. This is good practice.

There were satisfactory 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.

Satisfactory 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 prior to disposal.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and 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 and competency assessment, the management of medicines at admission and changes to prescribed medicines, medicine storage and the management of controlled drugs.

Areas for improvement

No areas for improvement were identified.

	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 sample of medicines examined had mostly 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, monthly or three monthly medicines were due.

The management of pain and dysphagia was reviewed and found to be satisfactory.

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 discussed with the patient and reported to the prescriber.

Medicine records were mostly well maintained and facilitated the audit process. A few missing signatures were observed on medication administration record sheets. These were discussed. The deputy manager was aware and was reviewing these records within audit procedures. Nurses were reminded to record every administration of pain relief administered on a 'when required' basis as most of the small number of audit discrepancies observed involved these medicines.

Practices for the management of medicines were audited regularly. In addition, audits were completed by the community pharmacist. Mostly satisfactory outcomes had been recorded.

Following discussion with the staff on duty and a review of the care plans, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in patient care.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 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.

We observed the administration of medicines to a small number of patients at lunchtime. The registered nurse engaged the patients in conversation and explained that they were having their medicines.

Throughout the inspection, it was found that there were good relationships between the staff and the patients. It was clear from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes. Patients were observed to be relaxed and comfortable.

We spoke briefly with three patients and one relative who were satisfied with the care provided and the staff in the home.

Ten questionnaires were left in the home to facilitate feedback from patients and their representatives. None were returned within the specified timescale (two weeks).

Any comments from patients and their representatives in questionnaires received after the return date will be shared with the registered manager for information and action as required.

Areas of good practice

There was evidence that 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
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.

We discussed arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the

diverse needs of patients. Arrangements were in place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. They were not reviewed on this occasion. Following discussion with staff it was evident that they were familiar with policies and procedures and that any updates were highlighted to them.

There were arrangements in place for the management of any medicine related incidents. Staff confirmed that they knew how to identify and report incidents and were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the audit records indicated that mostly satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken.

Following discussion with the registered nurses on duty, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date.

No online questionnaires were completed by staff 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

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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