Unannounced Medicines Management Inspection Report
13 February 2018

Holywood

Type of Service: Nursing Home
Address: 221 Old Holywood Road, Holywood, BT18 9QS
Tel no: 028 9042 6900
Inspectors: Paul Nixon

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 71 beds that provides care for patients with a variety of healthcare needs, as detailed in section 3.0.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** Ms Roxana Mitrea
Person in charge at the time of inspection: Ms Roxana Mitrea	**Date manager registered:** 5 January 2018
Categories of care: Nursing Homes I – Old age not falling within any other category. DE – Dementia. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. 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:** 71 A maximum of 18 patients in category NH-DE located on the ground floor and a maximum of 8 patients in categories NH-MP/MP(E) located in the Dunville Unit.

4.0 Inspection summary

An unannounced inspection took place on 13 February 2018 from 09.50 to 14.15.

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 medicine governance, medicine administration, medicines storage and the management of controlled drugs.

No areas requiring improvement were identified.

The patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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

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 19 October 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.

During the inspection we met with three patients, the registered manager, four registered nurses and two members of care staff.

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
- 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 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 19 October 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 15 February 2017

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 18 **Stated:** Second time	It is recommended that, if medication is prescribed on a "when required" basis for the management of distressed reactions, the care plan should identify the parameters for its administration and the reasons for administration and the outcome should be recorded.	**Met**
	Action taken as confirmed during the inspection: For four patients who were prescribed medication on a "when required" basis for the management of distressed reactions, whose records were examined, the care plans identified the parameters for its administration and the reasons for administration and the outcome were generally recorded.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered provider should ensure that there is a care plan covering the arrangement where a patient is administered medication in disguised form.	**Met**
	Action taken as confirmed during the inspection: For three patients whose records were examined, there were care plans covering the arrangement where medication was administered in disguised form.	

Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	The registered provider should ensure that, where appropriate, pain management care plans are maintained.	**Met**
	Action taken as confirmed during the inspection: For two patients whose records were examined, there were pain management care plans in place.	

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 in medicines management was provided in the last 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 medicine 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 controlled drug record books. 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. insulin and medicines administered through an enteral feeding tube. The use of separate recording 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. 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. Two in-use insulin pens did not have the dates of opening recorded; the registered manager gave an assurance that this matter would be addressed without delay.

Areas of good practice

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

The sample of medicines examined had generally been administered in accordance with the prescriber's instructions. A couple of discrepancies were drawn to the attention of the registered manager, who gave an assurance that the administrations of the medicines would be closely monitored.

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, fortnightly, monthly or three monthly medicines were due.

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. Administrations were 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 generally well maintained and facilitated the audit process. However, insulin prescribed for one patient was not recorded on their personal medication record sheet; the registered manager gave an assurance that this matter would be rectified without delay.

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

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

Throughout the inspection it was found that there were good relationships between the staff and patients. Staff were noted to be friendly and courteous; they treated the patients with dignity. From discussion and observation of staff, it was clear that they were familiar with the patients' needs, their likes and dislikes.

The patients we spoke with advised that they were content with the management of their medicines and the care provided in the home. Some comments made were:

- "Care is brilliant; staff are wonderful and so caring. Food is very good.
- "Care is first class. Staff are very friendly and willing to help. Food is first class."
- "Care is brilliant. Staff are most attentive. Food is brilliant."

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.

As part of the inspection process, ten questionnaires were left in the home to facilitate feedback from patients and their representatives. Five were returned within the specified timeframe. Comments received were positive; with responses recorded as 'very satisfied' with the management of medicines in the home. Comments included:

- "I am very pleased with the care….Patients are always clean and well looked after."
- "Most wonderful dedicated care of vulnerable people."
- "The most wonderful care…I am so grateful to everyone."

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
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. Following discussion with staff, it was evident that they were knowledgeable 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. Any anomalies in the medicine administration procedures identified by the robust internal auditing system were reported to RQIA as incidents. 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 registered manager, registered nurses and care staff, it was evident that staff were knowledgeable regarding 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 staff were open and approachable and willing to listen.

No members of staff shared their views by completing an online questionnaire.

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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