Unannounced Medicines Management Inspection Report
9 November 2018

Ambassador

Type of Service: Nursing Home
Address: 462-464 Antrim Road, Belfast, BT15 5GE
Tel No: 028 9077 1384
Inspector: Helen Daly

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 that provides care for up to 48 patients with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Amstecos Ltd **Responsible Individual(s):** Mrs Emer Bevan	**Registered Manager:** Mrs Amelia Noach
Person in charge at the time of inspection: Mrs Amelia Noach	**Date manager registered:** 1 April 2005
Categories of care: Nursing Homes (NH): A – past or present alcohol dependence 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 This number includes a maximum of two patients in category NH-A.

4.0 Inspection summary

An unannounced inspection took place on 9 November 2018 from 10.15 to 15.05.

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

No areas for improvement were identified at this inspection.

We spoke with one patient who was complimentary regarding the care and staff 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 residents experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Amelia Noach, Registered 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 19 July 2018. 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 home was reviewed. This included the following:

- recent inspection reports
- recent correspondence with the home
- the management of medicine related incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

During the inspection we met with one patient, the maintenance man, two registered nurses, the registered manager and the responsible individual.

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

We asked the registered manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

A sample of the registered 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 registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 19 July 2018

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 8 November 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:** First time	The registered person shall ensure that the management of distressed reactions is reviewed and revised. The reason for and outcome of the administration of "when required" medicines should be recorded.	**Met**
	Action taken as confirmed during the inspection: Detailed care plans for the management of distressed reactions were in place. The reason for and outcome of administration were recorded in the progress notes.	
Area for improvement 2 **Ref**: Standard 26 **Stated:** First time	The registered person shall ensure that care plans for the management of pain are in place for relevant patients.	**Met**
	Action taken as confirmed during the inspection: Detailed care plans for the management of pain were 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. Update training had been provided by the community pharmacist in May 2018. Competency assessments were updated regularly. Records were available for inspection. The registered manager advised that care assistants had received training and been deemed competent to administer thickening agents and emollient preparations.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training was provided annually for all staff.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and to manage medication changes. Personal medication records and hand-written entries on the medication administration records were verified and signed by two registered nurses. This safe practice was acknowledged.

There was evidence that antibiotics and newly prescribed medicines had been received into the home without delay. Registered nurses advised that there were ongoing difficulties with ensuring that all patients had a continuous supply of some of their prescribed medicines e.g. "when required" analgesia. This was discussed in detail and the registered manager advised that a system would be put in place to ensure that stock levels would be checked on a weekly basis and that prescriptions would be ordered for any medicines that had approximately seven days remaining.

Mostly satisfactory systems were observed for the management of high risk medicines e.g. insulin and warfarin. The use of separate administration charts was acknowledged. Dates of opening were recorded on all insulin pens to facilitate audit and disposal at expiry. However a small number of insulin pens remained in use after expiry. They were replaced during the inspection. The registered manager provided evidence that insulin pens were checked as part of the weekly audits and that this had been an oversight. It was agreed that this would be brought to the attention of all registered nurses. Due to the assurances provided an area for improvement was not specified at this 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.

Satisfactory arrangements were in place for the safe disposal of discontinued or expired medicines.

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. Risk assessments were in place for the storage of emollient preparations in patients' bedrooms. 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
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 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 distressed reactions, pain and thickening agents was reviewed and found to be satisfactory. Detailed care plans and records of prescribing and administration were in place.

Registered nurses advised 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. Registered nurses were commended for their ongoing efforts.

Practices for the management of medicines were audited throughout the month by the staff and management. The audits covered the management of insulin, distressed reactions, pain, inhalers and eye preparations, in addition to audit trails on the administration of medicines.

Following discussion with the registered manager and registered nurses, 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 the standard of record keeping, care planning, the auditing systems 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. The registered nurses engaged the patients in conversation and explained that they were having their medicines. It was clear from discussion and observation of staff, that they were familiar with the patients' likes and dislikes.

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. Patients were observed to be relaxed and comfortable.

We spoke with one patient who was complimentary regarding the care provided and staff in the home. Comments included:

"The staff are very good to you. You can go to bed and get up whenever you like. It's like a hotel. You can get whatever you want to eat. There is plenty to do, I enjoy the bingo. I don't want to go home."

As part of the inspection process, we issued 10 questionnaires to patients and their representatives, two were returned within the specified time frame. The responses indicated that relatives with satisfied/very satisfied with the care provided in the home.

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

Areas of good practice

Staff were observed to listen to patients and respond promptly to all requests.

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 within Ambassador.

Written policies and procedures for the management of medicines were in place. They were not reviewed at the inspection.

The registered manager advised that staff knew how to identify and report incidents. In relation to the regional safeguarding procedures, registered nurses advised that they were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were examined. Management advised of the auditing processes completed by both staff and management. Areas identified for improvement were shared with staff to address and there were systems in place to monitor improvement.

Following discussion with the registered nurses, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They advised that any concerns in relation to medicines management were raised with the registered manager.

The staff we met with spoke positively about their work and advised there were good working relationships in the home with staff and the registered manager. They stated they felt well supported in their work.

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 with 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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