Unannounced Medicines Management Inspection Report
8 November 2017

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 servicefrom 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 homewith 48 beds that provides care for patients with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Amstecos Ltd **Responsible Individual:** MrsEmer Bevan	**Registered Manager:** Mrs Amelia Noach
Person in charge at the time of inspection: MrsElizabeth Ninan(Registered Nurse)	**Date manager registered:** 1 April 2005
Categories of care: Nursing Home 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 A – past or present alcohol dependence TI – terminally ill	**Number of registered places:** 48

4.0 Inspection summary

An unannounced inspection took place on 8 November 2017 from 10.25 to 14.20.

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 identifiedsince 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, storage and the management of controlled drugs.

Areas requiring improvement were identified in relation to the documentation in place for distressed reactions and pain management.

Patients said that they were very content in the home and that staff were kind.

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.

4.1Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Elizabeth Ninan, Registered Nurse, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcementaction did not result from the findings of this inspection.

4.2Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIPno further actions were required to be taken following the most recent inspection on 26 October 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- 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 inspectionwe met with one patient, one care assistant and three registered nurses.

A total of 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
- 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 theinspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 26 October 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and is being reviewed by 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 27 October 2016

There were no areas for improvementmade as a result of the last medicines managementinspection.

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. Registered nurses had attended training provided by the community pharmacist in September 2017. Training was discussed with a recently recruited registered nurse and a care assistant; both were complimentary regarding their induction and regular training updates.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. The inspection was conducted on the first day of a new medication cycle and all medicines were available for administration; all potential issues had been addressed in a timely manner. 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 the majority of handwritten entries on medication 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 and discharge from 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.

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

Discontinued or expired medicines were disposed of appropriately. A separate book to record the denaturing and disposal of discontinued controlled drugs was in use.

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 robust systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission, 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 been administered in accordance with the prescriber's instructions. Prompts were in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

A number of patients were prescribed a medicine for administration on a "when required" basis for the management of distressed reactions. Care plans were in place and the dosage instructions were recorded on the personal medication records. 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 each administration were not being recorded. 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 tool was used as needed. Staff also advised that a pain assessment is completed as part of the admission process. A care plan was in place for only one of the three patients reviewed. An area for improvement was identified.

The management of swallowing difficulty was examined. Care plans and speech and language assessments were in place. Records of prescribing and administration included details of the prescribed consistency.

Staff confirmed that any medication 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. Areas of good practice were acknowledged. They included highlights for patients with similar names.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicines. Registered nurses completed weekly audits and the registered manager completed an audit at least monthly.

Following discussion with the registered nurses and staff, 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 and the administration of medicines.

Areas for improvement

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.

The registered person shall ensure that care plans for the management of pain are in place for relevant patients.

	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.

We observed the administration of medicines to a small number of patients. The registered nurses administering the medicines spoke to the patients in a kind and caring manner and the patients were given time to take their medicines.

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.

The patient spoken to at the inspection, 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. Their comments included,"It's very good. The staff are kind and I am not in any pain".

We observed the lunch being served. Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As part of the inspection process, we issued ten questionnaires to patients and their representatives; none were completed and returned within the specified timeframe. Any comments from patients, their representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

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. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report 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 lead and 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 care 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. They advised that management were open and approachable and willing to listen. Registered nurses were complimentary regarding the management team.

Comments included:

“I had an excellent induction. I had almost three weeks shadowing other staff. I came from another care home and I just felt that this home is like heaven because it is so organised.”
“This is a very friendly home. The manager is approachable. She likes to be asked questions and she likes to teach us.”

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 theQIP were discussed with Mrs Elizabeth Ninan, Registered Nurse, 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 standardsthis 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 improvementidentified 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 providershould confirm that these actions have been completed and return the completed QIPvia Web Portalfor 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:** 10 December 2017	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. Ref: 6.5
	Response by registered persondetailing the actions taken: A distress reaction tool with the following details is already in place, a) Name of resident b) D.O.B c) Date/ time d) Drug name e) Reason for giving f) Outcome g) Signature All registered nurses are fully aware of the distress/ reaction chart. Importance of documentation/ as listed above had again been highlighted. A reminder tool to document had been implemented to alert RGN's to document stat following administration. Following on recent inspection – the distress/ reaction tool is also part of our auditing process at weekends.
Area for improvement 2 **Ref:** Standard 26 **Stated:** First time **To be completed by:** 10 December 2017	The registered person shall ensure that care plans for the management of pain are in place for relevant patients. Ref: 6.5
	Response by registered persondetailing the actions taken: Since November 2017, all residents careplans had been reviewed in line with the Gold Crest computer system. All relevant residents on analgesia now have a care plan to review on a monthly basis and more often if needed. Primary RGN's are fully aware of updating their pain evaluations as well as their care plans.

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

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