Unannounced Medicines Management Inspection Report
25 January 2017

Annadale

Type of Service: Nursing Home
Address: 11 Annadale Avenue, Belfast, BT7 3JH
Tel no: 028 9064 5900
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Annadale took place on 25 January 2017 from 10.15 to 14.50.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence that most areas for the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. However, one area for improvement with regard to the maintenance of medication administration records was identified. A requirement was made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. There were no areas of improvement identified.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for patients. There were no areas of improvement identified.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. There were no areas of improvement identified.

This inspection was underpinned by 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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	0

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Winnie Mashumba, 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.

1.2 Actions/enforcement taken following the most recent premises inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 16 January 2017.

2.0 Service details

Registered organisation/registered person: Annadale Private Nursing Home Ltd Mr William Trevor Gage	**Registered manager:** Mrs Winnie Mashumba
Person in charge of the home at the time of inspection: Mrs Winnie Mashumba	**Date manager registered:** 21 October 2008
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 38

3.0 Methods/processes

Prior to inspection the following records were analysed:

- 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.

We met with two patients, two care assistants, two registered nurses and the registered manager.

Fifteen questionnaires were issued to patients, relatives/representatives and staff, with a request that they were returned within one week from the date of the inspection.

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
- medicine audits
- care plans
- medicines storage temperatures
- controlled drug record book

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 16 January 2017

The most recent inspection of the home was an announced premises inspection. The draft report was issued to the home on 2 February 2017. The returned QIP will be reviewed by the estates inspector when it is returned. This QIP will be validated by the estates inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 16 November 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 28 **Stated:** First time	The management of waste medicines should be reviewed and revised to ensure compliance with The Controlled Waste Regulations (Northern Ireland) 2002.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that the community pharmacy had provided assurances that the disposal of waste medicines was in compliance with The Controlled Waste Regulations (Northern Ireland) 2002. The lockable disposal container was at the community pharmacy on the day of the inspection.	
Recommendation 2 **Ref:** Standard 18 **Stated:** First time	The management of medicines which are prescribed to be administered "when required" for the management of distressed reactions should be reviewed and revised as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: A small number of patients were prescribed these medicines and they were being used occasionally. Improvement in the care plans and records were observed at this inspection.	

4.3 Is care safe?

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. In addition to in-house training on the management of medicines, registered nurses had attended update training provided by the Trust.

On the day of the inspection it was noted that for some patients the administration records had been completed prior to the actual administration of the medicines. The registered manager acknowledged that this practice was unsafe and unacceptable. She stated that it would be discussed immediately with the registered nurses and that extra measures would be put in place to ensure that the evening medicines were administered appropriately. A requirement was made.

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.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

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. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

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

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. 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 for improvement

The registered provider must ensure that medication administration records are completely appropriately after the medicines have been administered. A requirement was made.

Number of requirements	1	**Number of recommendations**	0

4.4 Is care effective?

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.

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. Care plans were in place; one needed to be updated. 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 recorded in the daily notes on some occasions. It was acknowledged that these medicines were rarely used and the registered manager agreed to closely monitor the records to ensure that the reason and outcome were recorded on all occasions.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place. 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. Staff also advised that a pain assessment was completed as part of the admission process.

The management of swallowing difficulty was examined. Care plans and speech and language assessment reports were in place. The thickening agent was recorded on the personal medication record and included details of the fluid consistency. Each administration was recorded.

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.

With the exception of some medication administration records which were "pre-signed" on the day of the inspection medicine records were well maintained and facilitated the audit process.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines, nutritional supplements, liquid medicines and inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.5 Is care compassionate?

The administration of medicines to patients was completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients confirmed that they were happy with the care provided in the home and were complimentary of staff and management.

As part of the inspection process 15 questionnaires were issued to patients, relatives/ representatives and staff, with a request that they were returned within one week from the date of the inspection. No responses were received by RQIA within this timescale.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

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. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents.

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 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 any resultant action was communicated with staff either individually or via team meetings.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Winnie Mashumba, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and the Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to pharmacists@rqia.org.uk for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 25 February 2017	The registered provider must ensure that medication administration records are completely appropriately after the medicines have been administered. **Response by registered provider detailing the actions taken:** Disciplinary action was taken against the nurse who was responsible for completing the medicines administration records prior to the actual administration. Further training on medicines administration was arranged and attended by all the nurses. We are carrying out random checks to ensure this does not happen again .

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews