Unannounced Medicines Management Inspection Report
1 September 2017

Arlington

Type of Service: Nursing Home
Address: 7-9 North Parade, Belfast, BT7 2GF
Tel No: 028 9049 1136
Inspector: Judith Taylor

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 25 beds that provides care for patients living with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Arlington **Responsible Individuals:** Mr Brian Macklin & Mrs Mary Macklin	**Registered Manager:** Ms Jacinta Silva
Person in charge at the time of inspection: Ms Jacinta Silva	**Date manager registered:** 22 February 2017
Categories of care: Nursing Home I – Old age not falling within any other category TI – Terminally ill PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 25

4.0 Inspection summary

An unannounced inspection took place on 1 September 2017 from 10.05 to 14.45.

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 care planning, the management of controlled drugs and administration of medicines.

Areas requiring improvement were identified in relation to the cold storage of medicines and the record keeping for medicines.

The patient and relatives spoken to were very complimentary regarding the care 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	3

Details of the Quality Improvement Plan (QIP) were discussed with Ms Jacinta Silva, 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 2 May 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: it was ascertained that no medicine related incidents had been 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 one patient, one registered nurse, two patients' relatives and the registered manager.

A total of 15 questionnaires were provided for distribution to patients, their representatives, visiting professionals and staff for completion and return to RQIA.

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
- policies and procedures
- care plans
- training records
- medicines storage temperatures

Areas for improvements 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 2 May 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 19 April 2016

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 28 **Stated:** First time	The registered person should ensure that the management of medicines which are prescribed to be administered "when required" for distressed reactions is reviewed and revised. Detailed care plans should be in place. The reason for and outcome of each administration should be recorded.	**Met**
	Action taken as confirmed during the inspection: The management of medicines prescribed for distressed reactions had been reviewed. Of the sample of patient records examined, a care plan was in place and the records of administration included the reason for and the outcome of the administration.	

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 the management of medicines and swallowing difficulty was provided in April and May 2017. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed in May 2017.

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 medication administration records were usually 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. However, the use of correction fluid was noted and discussed (see Section 6.5). 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.

The management of high risk medicines such as warfarin was reviewed. Written confirmation of the warfarin regime was in place and obsolete regimes were securely archived. A running stock balance was maintained; the benefit of maintaining a separate administration sheet for this medicine was discussed.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Following recent refurbishment, new storage areas had been developed for medicines. The medicines were stored safely and securely. Storage areas were clean, tidy and organised. Oxygen equipment was checked at regular intervals. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Staff were reminded that sachets of lidocaine patches must remain sealed when not in use.

The temperatures of medicine storage areas were monitored and recorded on a daily basis. It was found that the medicine refrigerator temperatures were frequently outside the accepted range of 2^{o}C to 8^{o}C, with higher maximum or lower minimum temperatures often recorded. This had not been recognised or reported for corrective action. The viability of medicines stored here was discussed. An area for improvement was identified.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessment and controlled drugs.

Areas for improvement

A system should be implemented to ensure that robust arrangements are in place for the cold storage of medicines.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The outcomes of the audit trails performed on the sample of medicines examined were mostly satisfactory, indicating that the medicines had been administered in accordance with the prescriber's instructions. However, a discrepancy was noted in one inhaled medicine; the manager provided assurances that this inhaled medicine would be closely monitored with immediate effect. The audit trails on some other medicines could not be concluded as there was no evidence of a record of the receipt of these medicines (see below).

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.

For one eye preparation, there was no evidence that this medicine had been administered as prescribed since 7 August 2017. There was no stock of the patient's eye preparation at the time of the inspection. This was investigated by the registered manager and written details of the findings and action taken were received by RQIA on 6 September 2017.

The management of distressed reactions, swallowing difficulty and pain were reviewed. The relevant information was recorded in the patient's care plan, personal medication record and records of administration.

When antibiotics were prescribed, a care plan was maintained. This is best practice.

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.

Some of the medicine records were well maintained and facilitated the audit process. However, in relation to the completion of personal medication records, it was found that some entries had been amended, including the use of correction fluid (see also Section 6.4) and some were incomplete. The registered manager advised that the personal medication records would be rewritten with immediate effect. A number of medicines had not been receipted correctly, this included medicines supplied in seven day blister packs and a few supplied in 28 day blister packs. A record of each individual medicine must be recorded on every occasion. For those medicines in seven day packs, details to identify each medicine in the blister should also be recorded. Two areas for improvement were identified.

Following discussion with the registered manager and staff, and a review of care files, it was evident that, when applicable, other healthcare professionals were contacted in response to the patient's healthcare needs.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the care planning and the administration of medicines.

Areas for improvement

The following areas for improvement were identified:

- the registered person should closely monitor the systems in place for the receipt of medicines
- a system should be developed to ensure that all staff are aware of how to record errors on medicine records and that correction fluid is not used.

	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.

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.

Throughout the inspection, it was evident that there was a good rapport between patients and staff. The staff treated the patients with respect and their approach was friendly and kind. They listened to the patients' requests.

Some of the patients were noted to be enjoying the afternoon activities which had commenced during the inspection.

The patient we spoke with was content with the management of their medicines and the care provided in the home.

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.

We spoke with two relatives who were very complimentary about the staff and the good standard of care provided.

Of the questionnaires that were issued, four were received from patients, two from relatives and three from staff. The responses indicated they were very satisfied/satisfied with all aspects of the care in relation to the management of medicines. One comment made regarding patient care was 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.

Written policies and procedures for the management of medicines were in place. These had been updated in April 2016. Following discussion with staff it was evident that they were familiar 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.

Practices for the management of medicines were audited by on a monthly basis by the registered manager. An audit was also completed at least annually by the community pharmacist. A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, the registered manager advised of the procedures in place to ensure that all staff were made aware and how it was to be actioned.

Following discussion with the registered manager and registered nurse, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. It was confirmed that any medicines related concerns were raised with management.

Areas of good practice

There were examples of good practice found throughout the inspection 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 the QIP were discussed with Ms Jacinta Silva, Registered Manager, 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 standards this 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 improvement identified 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 provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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 30 **Stated:** First time **To be completed by:** 1 October 2017	The registered person shall review the management of medicines to ensure there are robust arrangements in place for the cold storage of medicines. Ref: 6.4
	Response by registered person detailing the actions taken: Service done. Keep fridge only 50% full. temperatures been checked and recorded between 2-8c.
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 1 October 2017	The registered person shall review the procedures for the receipt of medicines to ensure that full and accurate records are maintained. Ref: 6.5
	Response by registered person detailing the actions taken: New book in place to record receipt of medicines. supervision with nursing team 4/9/2017 to ensure all medicines are recorded.
Area for improvement 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 1 October 2017	The registered person shall review the management of recording errors. Ref: 6.5
	Response by registered person detailing the actions taken: Supervision done with nursing team 4/9/2017 to ensure all medicines are precribed, received and checked before start new cicle. Audits and investigation completed by Nurse MAnager 6/9/2017.

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

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