Unannounced Medicines Management Inspection Report
8 December 2016

Beechill

Type of Service: Nursing Home
Address: 12 Royal Lodge Road, Belfast, BT8 4UL
Tel no: 028 9040 2871
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Beechill took place on 8 December 2016 from 10.25 to 14.30.

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 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. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. There were no areas of improvement identified.

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. Two areas for improvement in relation to the management of distressed reactions and the archiving of records were identified. Two recommendations were made.

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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Priscilla Abrenica, Acting 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 care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 14 June 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** See below
Person in charge of the home at the time of inspection: Mrs Priscilla Abrenica	**Date manager registered:** Mrs Priscilla Abrenica, Acting Manager (no application required)
Categories of care: NH-DE	**Number of registered places:** 34

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; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

We spoke with one care assistant, one registered nurse and the acting manager.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

Twenty questionnaires were issued to patients, relatives/patients' 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
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 June 2016

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 their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 15 October 2015

There were no requirements or recommendations made as a result of the last medicines management 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. Refresher training had been planned for 6 December 2016 but had been cancelled; the acting manager advised that it would be rescheduled.

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. Additional checks were also performed on other controlled drugs which is good practice.

Mostly satisfactory arrangements were observed to be in place for the management of high risk medicines e.g. warfarin. Dosage directions were received in writing and transcribing involved two staff. Running stock balances were maintained. Obsolete dosage directions had not been cancelled and archived. A recommendation regarding the cancellation and archiving of records was made under Section 4.4.

Appropriate arrangements were in place for administering medicines in disguised form.

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.
A number of temperatures outside the accepted range were observed for the refrigerator in the treatment room on the first floor. The acting manager advised that this had been noted and a replacement easy read thermometer had been obtained. It was agreed that this would be put in place and the temperatures would be closely monitored.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	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. 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. Care plans for some but not all patients were in place. The reason for and outcome of administration had been recorded on some occasions only.
A recommendation was made.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were maintained. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff confirmed that pain assessment tools were used with patients who were unable to verbalise their pain. Staff also advised that a pain assessment tool was completed as part of the admission process.

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. Care plans and speech and language assessment reports were in place. Administration was being recorded either on the medication administration records or on the daily diet sheets.

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 well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included highlights for any alerts, prompts for medicines which were administered weekly and 'when required protocols' for analgesics and laxatives. A number of obsolete personal medication records were available in the medicines file. A recommendation was made.

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, liquid medicines and inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

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

Areas for improvement

The registered provider should review and revise the management of distressed reactions. Detailed care plans should be in place. The reason and outcome of each administration of 'when required' medicines should be recorded. A recommendation was made.

The registered provider should ensure that obsolete personal medication records and warfarin dosage directions are cancelled and archived. A recommendation was made.

Number of requirements	0	**Number of recommendations**	2

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 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 20 questionnaires were issued to patients, relatives/patients' representatives and staff, with a request that they were returned within one week from the date of the inspection. Two members of staff completed and returned the questionnaires. The responses were positive and these were recorded as "satisfied" or "very satisfied" with regard to the management of medicines in the home.

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. Management advised that these were reviewed regularly. 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 had been no medicine related incidents reported since the last medicines management inspection.

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 acting manager, registered nurse 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 Priscilla Abrenica, Acting 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 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 **the web portal** 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

Recommendations	
Recommendation 1 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 8 January 2017	The registered provider should review and revise the management of distressed reactions. Detailed care plans should be in place. The reason and outcome of each administration of 'when required' medicines should be recorded.
	Response by registered provider detailing the actions taken: This has been addressed with all trained staff-that any 'when required' medicine administered for distressed reactions-they will document the reason why to administer the said medicine and assess the efficacy which should be recorded. Care plan is in place and evaluated regularly or as needed.
Recommendation 2 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 8 January 2017	The registered provider should ensure that obsolete personal medication records and warfarin dosage directions are cancelled and archived.
	Response by registered provider detailing the actions taken: Trained staff was made aware to archive all the obsolete forms and to ensure to use the right form to monitor the warfarin dosage and stock left.

Please ensure this document is completed in full and returned to the web portal

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