Unannounced Medicines Management Inspection Report
24 June 2016

Belmont

Type of Service: Nursing Home
Address: Parklands Close, 81 Tillysburn Park, Belfast, BT4 2PD
Tel No: 028 9076 3408
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Belmont took place on 24 June 2016 from 09:50 to 14:00.

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 the 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. 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. There were no areas of improvement identified.

Is care compassionate?
There was evidence that the management of medicines supported the delivery of compassionate care. Where possible patients were involved in the management of their medicines and there was evidence of patients being enabled to self-administer their medication. Staff interactions were observed to be compassionate, caring and timely. Patients consulted with confirmed that they were administered their medicines appropriately. 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.

No requirements or recommendations were made at the last medicines management inspection in 2013 and no requirements or recommendations were identified within any of the domains at this inspection. This evidences that over time the management of medicines within Belmont has supported the delivery of a well led service which has resulted in positive outcomes for patients.

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	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Victoria Lane, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection on 2 June 2016.

2.0 Service details

Registered organisation/registered provider: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Mrs Victoria Lane
Person in charge of the home at the time of inspection: Mrs Victoria Lane	**Date manager registered:** 4 July 2012
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 48

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 three patients, the registered manager, three registered nurses and a care assistant.

A sample of the following records was examined:

- 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 2 June 2016

The most recent inspection of the home was an unannounced care inspection; no requirements or recommendations were made.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 11 April 2013

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 or if a need was identified.

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.

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. 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.

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 were in place. Records to document the reason for each administration and evaluate the effectiveness of the medication were in place. Whilst the use of these additional records is good practice, it was noted that these records had not been completed on all occasions. The registered manager agreed to discuss this with all registered nurses and monitor adherence.

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 assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment tool was completed as part of the admission process. The reason for and outcome of each administration of analgesics which are prescribed to be administered "when required" had been recorded; this is good practice.

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. Care assistants knew the required consistency for each patient as it was recorded in the nutrition file. It was agreed that each administration of thickening agents would be recorded in the "daily food and fluid booklets"; the registered manager advised that the maintenance of these records would be closely monitored.

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 the standard of maintenance of the medicines files and the alerts for patients with similar names.

Practices for the management of medicines were audited throughout the month by both staff and management. This included running stock balances for several solid dosage medicines, nutritional supplements and inhaled medicines. A review of the running stock balance records indicated that they had been maintained accurately.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medicines 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?

Appropriate arrangements were in place to facilitate patients responsible for the self-administration of medicines.

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.

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 available in the treatment rooms. 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 these incidents. A recent incident had been referred to the trust; the registered manager had completed a thorough investigation and sourced appropriate training for registered nurses.

A review of the home's audit records indicated that largely satisfactory outcomes had been achieved. Staff advised that if a discrepancy is identified it is investigated and shared by management for learning.

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 all staff either face to face or at team meetings.

As part of the governance system within the home, the registered manager advised that she was working that day as a care assistant in order to observe care practices. She advised that she also worked shifts "on the floor" to support registered nurses and promote consistency of working practices. This also enabled her to identify training needs to ensure that positive outcomes for patients are delivered at all times.

No requirements or recommendations were made at this inspection or the last medicines management inspection in 2013. This evidenced that the service is well led and has delivered positive outcomes for the patients over time

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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