Unannounced Medicines Management Inspection Report
4 May 2017

Colinvale Court

Type of Service: Nursing Home
Address: Glen Road, Belfast, BT11 8BU
Tel No: 028 9060 4314
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Colinvale Court took place on 4 May 2017 from 10:00 to 14:20.

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 largely 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. One area of improvement was identified in relation to having systems in place to alert staff of the expiry dates of medicines with a limited shelf life once opened and a recommendation was made.

Is care effective?

Improvement was required to ensure that the management of medicines supported the delivery of effective care. Areas of improvement were identified in relation to the administration of transdermal opioid patches, the maintenance of the receipt of medicines record and having a care plan for each patient who is prescribed medication for administration on a "when required" basis for the management of distressed reactions. Two requirements and one recommendation 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 for improvement identified

Is the service well led?

The service was found to generally 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. One area for improvement was identified regarding having robust arrangements in place to audit all aspects of the management of medicines and a recommendation was made.

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	2	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Vincy Vincent, 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 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 16 February 2017.

2.0 Service details

Registered organisation/registered provider: Colinvale Court / Mr. Raymond Liam Murphy	**Registered manager:** Mrs Vincy Vincent
Person in charge of the home at the time of inspection: Mrs Vincy Vincent	**Date manager registered:** 13 June 2016
Categories of care: NH-DE	**Number of registered places:** 50

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home

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

We met with the registered manager, one registered nurse and two members of care staff.

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.

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

The following records were 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
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 16 February 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 their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection 7 June 2016

There were no requirements of 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 in medicines management was provided in the last year. The most recent training was in relation to dysphagia.

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 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/readmission to the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. 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. insulin.

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. The medicine refrigerator and oxygen equipment were checked at regular intervals. Several eye-treatment medicines did not have the date of opening recorded; a recommendation was made.

Areas for improvement

There should be systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. A recommendation was made.

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

4.4 Is care effective?

The sample of medicines examined had generally been administered in accordance with the prescriber's instructions. However, discrepancies were observed in the administrations of two transdermal opioid patches and one antibiotic course.

During March 2017, two patients had delays in the application of their transdermal opioid patches, which were prescribed to be applied every seven days. One patient had gaps between applications of 14 days and nine days respectively. The other patient had a 12 day gap between applications. A requirement was made.

A discrepancy was observed in one patient's antibiotic course. Subsequent to the inspection, the registered manager investigated this observation and advised RQIA that the prescribed dose had not been administered on 3 May 2017. She stated that an antibiotic countdown record had been introduced and she would audit antibiotics weekly.

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 and 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. The reason for and the outcome of administration were recorded. However, for two of the three patients whose records were examined, a care plan was not maintained; a recommendation was made.

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. Pain assessment tools were used and care plans were maintained. Staff also advised that a pain assessment is 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. Administrations were recorded and care plans and speech and language assessment reports were in place.

The management of antibiotics was examined. The advice of the general medical practitioner had been recorded in the patient's notes and the antibiotic had been obtained without delay. One medicine had been administered appropriately; however, as stated above, two doses of another antibiotic had not been administered.

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.

The personal medication records, medicine administration records and disposal of medicines records were well maintained and facilitated the audit process. However, some gaps were observed in the receipt of medicines record; a requirement was made.

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

Areas for improvement

Transdermal opioid patches must be administered in accordance with the prescriber's instructions. A requirement was made.

For each patient who is prescribed a medicine for administration on a "when required" basis for the management of distressed reactions there should be a care plan detailing the circumstances under which the medicine is to be administered. A recommendation was made.

The receipt of medicines record must be fully maintained. A requirement was made.

Number of requirements	2	**Number of recommendations**	1

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, we issued questionnaires to patients, patients' representatives and staff. One patient's representative completed and returned questionnaires within the specified timeframe. Comments received were very positive; the responses were recorded as 'very satisfied' with the management of medicines in the home.

Three members of staff also completed a questionnaire. The responses were positive and raised no concerns about 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. 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. No medicine related incidents had been reported to RQIA since the previous medicines management inspection.

Staff knew that medicine incidents should be considered under safeguarding procedures and how to report these.

The level of medicines management audit activity by management had significantly reduced since the previous medicines management inspection. The monthly audit tool was no longer used and, with the exception of controlled drugs, only a very small number of medicines had been audited over the previous few months. The audits of controlled drugs had not highlighted the discrepancies found during this inspection. The registered manager needs to review and revise the medicines management audit arrangements to ensure they are robust and cover all aspects of the management of medicines; a recommendation was made.

Following discussion with the registered 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.

Areas for improvement

There should be robust arrangements in place to audit all aspects of the management of medicines. A recommendation was made.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Vincy Vincent, 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 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:** 3 June 2017	The registered provider must ensure that transdermal opioid patches are administered in accordance with the prescriber's instructions.
	Response by registered provider detailing the actions taken: The nurse manager has spoken to all nursing staff in relation to the administration of the transdermal opioid patches and further group supervision has been provided . The nurse manager will introduce regular check to ensure that the patches are administered on the appropriate day
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 3 June 2017	The registered provider must ensure that the receipt of medicines record is fully maintained.
	Response by registered provider detailing the actions taken: A new system of recording medicines received has been introduced and additional group supervision relating to this has been carried out with nursing staff .
Recommendations	
Recommendation 1 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 3 June 2017	The registered provider should ensure that there are systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened.
	Response by registered provider detailing the actions taken: Nursing staff have been instructed to dispose of all out of date medicines ,creams ,eyedrops etc in appropriate way. Also ,instructed nursing staff to update their diary regularly to ensure that to change the eye drops in appropriate time .
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 3 June 2017	The registered provider should ensure that, for each patient who is prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, there is a care plan detailing the circumstances under which the medicine is to be administered.
	Response by registered provider detailing the actions taken: Nurses have been given futher supervision by the nurse manager to update care plans and make relevent daily notes to ensuring that medication prescribed when required is provided at the appropriate time and also record the effcect of the medication

Recommendation 3 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 3 June 2017	The registered provider should ensure there are robust arrangements in place to audit all aspects of the management of medicines.
	Response by registered provider detailing the actions taken: The nurse manager has undertaken to carry out monthly audit of medicines to ensure that robust arrangements are in place to audit all aspect of the management of medicines with approprite audit tool

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