Unannounced Medicines Management Inspection Report
7 June 2016

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 7 June 2016 from 09.30 to 13.40.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern.

Is care safe?

No requirements or recommendations have been made.

Is care effective?

No requirements or recommendations have been made.

Is care compassionate?

No requirements or recommendations have been made.

Is the service well led?

No requirements or recommendations have been 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 prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008. Please refer to section 4.2 of this report.

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 Ms Vincy Vincent, Nurse 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

Other than those actions detailed in the previous QIP, there were no further actions required to be taken following the last inspection on 15 February 2016.

2.0 Service details

Registered organisation/registered provider: Colinvale Court/ Mr. Raymond Liam Murphy	**Registered manager:** See box below
Person in charge of the home at the time of inspection: Ms. Vincy Vincent	**Date manager registered:** Ms. Vincy Vincent - application received - "registration pending"
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
- the management of medicine related incidents reported to RQIA since the last medicines management inspection

During the inspection the inspector met with the nurse manager, one registered nurse and two care staff.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector. No-one availed of this opportunity.

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
- 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 15 February 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 inspection dated 2 March 2015

Last medicines inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must ensure that robust systems are in place if families are sharing responsibility for acquiring medicines during periods of respite care to ensure that patients have a continuous supply of their prescribed medication.	**Met**
	Action taken as confirmed during the inspection: The management of two recently admitted patients' medication was examined. Appropriate arrangements had been made to ensure that the patients had a continuous supply of their medication.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must ensure that a robust system is in place for the management of warfarin dosage directions and the recording of warfarin stock balances.	**Met**
	Action taken as confirmed during the inspection: A robust system was in place for the management of warfarin. The prescriber confirmed the dosage directions in writing. Running stock balances had been maintained.	

Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must investigate the reasons for the unsatisfactory audit outcomes on Abilify 1mg/ml solution and Seretide 250 Evohaler, each prescribed for one patient. A written response, detailing the outcomes of this investigation, must be submitted to RQIA with the completed Quality Improvement Plan.	**Met**
	Action taken as confirmed during the inspection: An investigation into these incidents was undertaken and a response, detailing the outcomes of the investigation, was submitted to RQIA.	
Last medicines inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37 **Stated:** Second time	In an instance where a patient is prescribed 'when required' medication for distressed reactions, the reason for and outcome of administration should be routinely recorded.	**Met**
	Action taken as confirmed during the inspection: Where a patient was prescribed 'when required' medication for distressed reactions, the reason for and outcome of administration were broadly recorded.	
Recommendation 2 **Ref**: Standard 38 **Stated:** First time	The thickening agent consistency should be routinely recorded on the daily fluid and food intake charts.	**Met**
	Action taken as confirmed during the inspection: Appropriate arrangements were observed for the recording of the use of thickening agents on the medicine administration records and fluid intake charts.	
Recommendation 3 **Ref**: Standard 38 **Stated:** First time	Handwritten entries on the medication administration record sheets should be consistently signed by two nurses.	**Met**
	Action taken as confirmed during the inspection: Handwritten entries on the medicine administration record sheets had been consistently signed by two nurses.	

4.3 Is care safe?

Medicines were managed by staff who had been trained and deemed competent to do so. An induction process was in place. Refresher training in medicines management was provided annually. Care staff had received training in the use of thickening agents. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed at the end of the induction period and annually thereafter.

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 patients' admissions to and discharges from 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; this was acknowledged as good practice.

Robust arrangements were observed for the management of high risk medicines e.g. insulin.

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 manufacturers' instructions. Medicine storage areas were clean, tidy and well organised. The medicine refrigerator 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 prescribers' instructions. A couple of audit discrepancies were drawn to the attention of the nurse manager, who gave an assurance that the administrations of the medicines would be closely monitored to ensure compliance with the prescribers' instructions. There was evidence that time critical medicines had been administered at the correct time. Arrangements were 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 parameters for administration were recorded on the personal medication record. A care plan was maintained. The reason for and outcome of administration had mostly been recorded. 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 sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff advised that a pain assessment was completed as part of the admission process. A pain tool was completed and updated as necessary. A care plan was maintained and it was evaluated on a monthly basis. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable.

The management of swallowing difficulty was examined. The thickening agent was recorded on the patient's personal medication record and the details of the fluid consistency were recorded. Administrations were generally recorded and a care plan and a speech and language assessment report were in place.

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 maintained in a satisfactory manner and facilitated the audit process. Areas of good practice were acknowledged. They included additional records for insulin and opioid transdermal patches. For a couple of eye-preparations, the route of application was not recorded on the personal medication records; the nurse manager gave an assurance that this matter would be rectified.

Practices for the management of medicines were audited throughout the month by the management and staff. The dates and times of opening of the medicine containers were recorded in order to facilitate audit; this was acknowledged as good practice. Running stock balances were maintained on most medicines not dispensed in the monitored dosage system blister packs.

Following discussion with the nursing staff and a review of care files, it was evident that, when applicable, other healthcare professionals were contacted in response to issues or concerns in relation to medicines management

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 several patients was observed during the inspection. Medicines were administered to patients in the living rooms or in their own rooms. The registered nurses administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to swallow each medicine. Extra time and attention was given to patients who had difficulty swallowing some of the medicines. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

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.

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 knowledgeable of these policies and procedures and that any updates were highlighted to them by management.

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 staff, it was evident that they 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

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.

Please provide any additional comments or observations you may wish to make below:

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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