Unannounced Medicines Management Inspection Report
21 March 2017

Three Rivers

Type of Service: Nursing Home
Address: 11 Millbank Lane, Lisnamallard, Omagh, BT79 9YD
Tel No: 028 8225 8227
Inspectors: Frances Gault and Helen Daly

1.0 Summary

An unannounced inspection of Three Rivers took place on 21 March 2017 from 10.15 to 13.30.

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. In the interests of safe practice the registered provider should ensure that any transcribing on the medicine administration records is signed by two trained members of staff. A recommendation was made.

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 for improvement identified.

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. Patients consulted with confirmed that they were administered their medicines appropriately. There were no areas for 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 for 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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Three Rivers which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Camilia Donnelly, 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 27 July 2016.

2.0 Service details

Registered organisation/registered person: Zest Care Homes Ltd Mr Philip Scott	**Registered manager:** See box below
Person in charge of the home at the time of inspection: Ms Camilia Donnelly (Acting Manager)	**Date manager registered:** Acting – no application required
Categories of care: NH-PH, RC-DE, NH-DE, NH-I	**Number of registered places:** 81

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 spoke with three patients, one senior care assistant, three registered nurses, the acting manager and two visiting professionals.

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

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 inspectors. No one availed of this opportunity during 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 27 July 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 5 March 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 in medicines management had been provided by the community pharmacist within the last month. The acting manager confirmed that training on the management and administration of medicines via the enteral route and syringe drivers had been provided by the Trust. A sample of training records was provided for inspection.

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 mostly satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses or trained care staff. This safe practice was acknowledged. Hand written updates on the medication administration records were signed and verified by two trained staff in the nursing units but this practice was not observed in the residential unit. A recommendation was made that senior care assistants would commence this practice and that it would be closely monitored by the acting manager.

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged.

The management of medicines via the enteral route and syringe drivers was reviewed and found to be mostly satisfactory. It was agreed that a revised document to facilitate the recording of the administration of all fluids, including flushes, via the enteral route would be developed and brought into use. The need for this documentation had already been identified by the unit sister.

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

The registered provider should ensure that any transcribing on the medicine administration records is signed by two trained members of staff. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

The sample of medicines examined had been administered in accordance with the prescriber's instructions. One discrepancy was identified and discussed with the unit sister and acting manager for review and close monitoring.

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. Care plans were maintained. 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 on most occasions. We spoke with a behavioural support nurse from the Trust who spoke positively on how "when required" medicines were managed in the home.

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 a pain assessment tool was used with patients who could not verbalise pain. Care plans for the management of pain were maintained. Staff also advised that a pain assessment is completed as part of the admission process.

The management of swallowing difficulty was examined. Care plans and speech and language assessment reports were in place. Records of prescribing and administration were maintained. The required consistency levels were clearly documented.

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 majority of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. Staff were reminded that the date of writing/rewriting of each personal medication record should be recorded and that the date of prescribing should not be amended each time a personal medication record is rewritten. In the residential unit it was noted that although the medicine round was finished the records of administration had not been signed. This was discussed with the senior care assistant. The acting manager advised that she would remind all registered nurses and senior carer assistants to sign the administration records immediately after they had been administered to each patient.

Practices for the management of medicines were audited throughout the month by the staff and management. This included daily, weekly and monthly audits.

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

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

The acting manager advised that appropriate arrangements were in place to facilitate patients to self-administer their medicines but that no one was doing this at present.

The morning medicines were just finishing at the commencement of the inspection. The one medicine administration observed indicated that staff gave patients time and encouragement to take their medicines. Discussions with the registered nurses and senior care assistant indicated that they were aware of each patients' individual needs and preferences.

The patients spoken with expressed satisfaction with their care. One patient advised that the place was "top notch."

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 15 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 patients, one relative and four 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. The relative commented that "the staff were outstanding in all respects". One member

of staff commented that sometimes there was a delay in the administration of medicines for the management of Parkinson's. This was raised with the deputy manager, by telephone after the inspection, for discussion with staff and with the care inspector for ongoing review. The deputy manager advised that this had been highlighted to staff and that it would be closely monitored. She advised that training on the management of Parkinson's had been arranged.

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 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 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 the acting 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 staff either individually or via team meetings. The acting manager was undertaking group supervision when we arrived in the home.

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 Ms Camilia Donnelly, 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 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	
Recommendations	
Recommendation 1 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 21 April 2017	The registered provider should ensure that any transcribing on the medicine administration records is signed by two trained members of staff.
	Response by registered provider detailing the actions taken: All staff are informed that two signatures is required. Management will inculde a check in weekly audit to ensure the same.

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address

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