Unannounced Medicines Management Inspection Report
3 May 2016

Edgewater

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Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Edgewater took place on 3 May 2016 from 10.15 to 13.35.

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 though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

Is care safe?
Two recommendations have been made.

Is care effective?
Two recommendations have been made.

Is care compassionate?
No requirements or recommendations have been made.

Is the service well led?
One recommendation has 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 as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 standards until compliance is achieved.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	5

Details of the QIP within this report were discussed with Mr John Green, Registered Manager and the nursing sister, 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 estates inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the most recent inspection on 20 January 2016.

2.0 Service details

Registered organisation/registered person: Edgewater/ Mr Michael Curran & Mr Paul Steele	**Registered manager:** Mr John Green
Person in charge of the home at the time of inspection: Mr John Green	**Date manager registered:** 14 December 2007
Categories of care: NH-I	**Number of registered places:** 28

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- incidents register - it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

We met with two patients and two registered nurses.

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 20 January 2016

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 3 June 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must closely monitor the administrations of Spiriva capsules and lidocaine patches, in order to ensure compliance with the prescribers' instructions.	**Met**
	Action taken as confirmed during the inspection: There was evidence of regular monitoring of lidocaine patches. Spiriva capsules were not prescribed for any patient at the time of the inspection; however, it was confirmed that this medicine had been closely audited following the last medicines management inspection.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must ensure that the information recorded on the personal medication record and medication administration record sheets always correlates.	**Met**
	Action taken as confirmed during the inspection: With the exception of a few medicine entries, the sample of personal medication records correlated with the corresponding medication administration records.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	Prescriptions should be received and checked in the home before dispensing.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that all prescriptions were viewed by staff before being dispensed at the pharmacy. He also advised that a copy of prescriptions was kept in the home.	
Recommendation 2 **Ref**: Standard 37 **Stated:** First time	The registered manager should update the written procedure detailing the arrangements for the disposal of medicines.	**Met**
	Action taken as confirmed during the inspection: A written procedure regarding the disposal of medicines in Edgewater had been updated to reflect current practice.	
Recommendation 3 **Ref**: Standard 37 **Stated:** First time	The registered manager should expand the written procedures detailing the arrangements for the management of controlled drugs.	**Met**
	Action taken as confirmed during the inspection: Standard operating procedures for controlled drugs were in place.	
Recommendation 4 **Ref**: Standard 37 **Stated:** First time	In order to facilitate audit activity, the dates of opening should be routinely recorded on all medicines not contained in the monitored dosage system blister packs.	**Met**
	Action taken as confirmed during the inspection: The medicines which were audited at the inspection were marked with the date of opening.	

Recommendation 5 **Ref**: Standard 38 **Stated:** First time	The removal of lidocaine patches should be recorded.	**Met**
	Action taken as confirmed during the inspection: The registered manager had developed a separate administration chart for lidocaine patches, which included staff signatures to denote the removal of the patch.	
Recommendation 6 **Ref**: Standard 38 **Stated:** First time	The registered manager should review the arrangements for the recording of the prescribing and administration of thickening agents.	**Met**
	Action taken as confirmed during the inspection: This had been reviewed. Records of administration were completed by the registered nurses and care staff.	

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 general 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.

The arrangements to manage changes to prescribed medicines should be reviewed. It was found that where the medicines had been supplied in the original containers and then changed to a monitored dosage medicine system, both supplies of medicines were stored on the medicine trolley. This has the potential to lead to an error in the administration of these medicines. This was discussed with the staff on duty. For one patient the medicine audits could not be concluded and it could not be determined if the correct dose had been administered. A recommendation was made. The recording of medicine changes on personal medication records and handwritten entries on medication administration records were not updated by two members of trained staff to ensure the accuracy of the transcribing. This is safe practice and a recommendation was made.

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.

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 necessary arrangements should be made to ensure that only one supply of the patient's medicines is stored on the medicine trolley. A recommendation was made.

The management of medicine changes should be reviewed to ensure that all updates to personal medication records and handwritten entries on medication administration records involve two members of trained staff and both initial the entry. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.4 Is care effective?

The majority of medicines examined had been administered in accordance with the prescriber's instructions. Some discrepancies were observed and highlighted with staff at the inspection. 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 medicines were due. Advice was given in relation to recording the date of when the next dose of three monthly injectable medicines was 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. A record of the reason for and the outcome of the administration was not maintained and a care plan was not in place. 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. 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 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 prescribed fluid consistency. Each administration was recorded and care plans and speech and language assessment reports 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.

Most of the medicine records were well maintained and facilitated the audit process. Some improvements were identified and discussed. For one patient, the receipt of one month's supply of medicines had not been recorded; staff advised that this was an oversight. It was agreed that this would be addressed after the inspection. The records of disposal of medicines, indicated that only one member of staff had been involved in the disposal of medicines. This was discussed in relation to best practice and a recommendation was made.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to issues or concerns regarding medicines management.

Areas for improvement

The management of medicines which are prescribed on a "when required" basis for the management of distressed reactions should be reviewed to ensure that a detailed care plan is developed and the reason for and outcome of any administration is recorded. A recommendation was made.

Two members of trained staff should be involved in the disposal of medicines and both staff should sign the record of disposal. 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.

Two patients advised that they were satisfied with the manner in which their medicines were managed and administered.

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. These had been reviewed in 2015. 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.

A review of the internal audit records indicated that practices for the management of medicines were audited every month by the registered manager and staff completed weekly audits. It was noted that the weekly audits mainly focused on medicines which were supplied in the monitored dosage system. A variety of medicines formulations should be included in the audit process. A recommendation was made. Advice was given regarding the recording of running stock balances for medicines.

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.

Areas for improvement

The procedures to audit the management of medicines should be reviewed to ensure that they cover all areas of medicines management. A recommendation was made.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr John Green, Registered Manager, and the nursing sister, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. 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 person/s 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 the DHSSPS Care Standards for Nursing Homes (2015). They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to pharmacists@rqia.org.uk and assessed 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 person/manager 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 person/manager 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 28 **Stated:** First time **To be completed by:** 6 June 2016	The necessary arrangements should be made to ensure that only one supply of the patient's medicines is stored on the medicine trolley.
	Response by registered person detailing the actions taken: Action taken to immediately remove any excess meds and staff aware of importance of ensuring one supply kept stored on trolly.
Recommendation 2 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 6 June 2016	The management of medicine changes should be reviewed to ensure that all updates to personal medication records and handwritten entries on medication administration records involve two members of trained staff and both initial the entry.
	Response by registered person detailing the actions taken: Action immediately taken. All staff aware of this and management and senior staff to ensure same is adhered to.
Recommendation 3 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 6 June 2016	The management of medicines which are prescribed on a "when required" basis for the management of distressed reactions should be reviewed to ensure that a detailed care plan is developed and the reason for and outcome of any administration is recorded.
	Response by registered person detailing the actions taken: Any patients with medication related to distressed reactions and reason for administration is recorded in a care plan. All staff aware and care notes will be audited to reflect same being done.
Recommendation 4 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 6 June 2016	Two members of trained staff should be involved in the disposal of medicines and both staff should sign the record of disposal.
	Response by registered person detailing the actions taken: Staff aware and same immediately done.
Recommendation 5 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 6 June 2016	The procedures to audit the management of medicines should be reviewed to ensure that they cover all areas of medicines management.
	Response by registered person detailing the actions taken: All meds now covered in audit, reviewed audit sheets put immediately in place and adhered to.

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