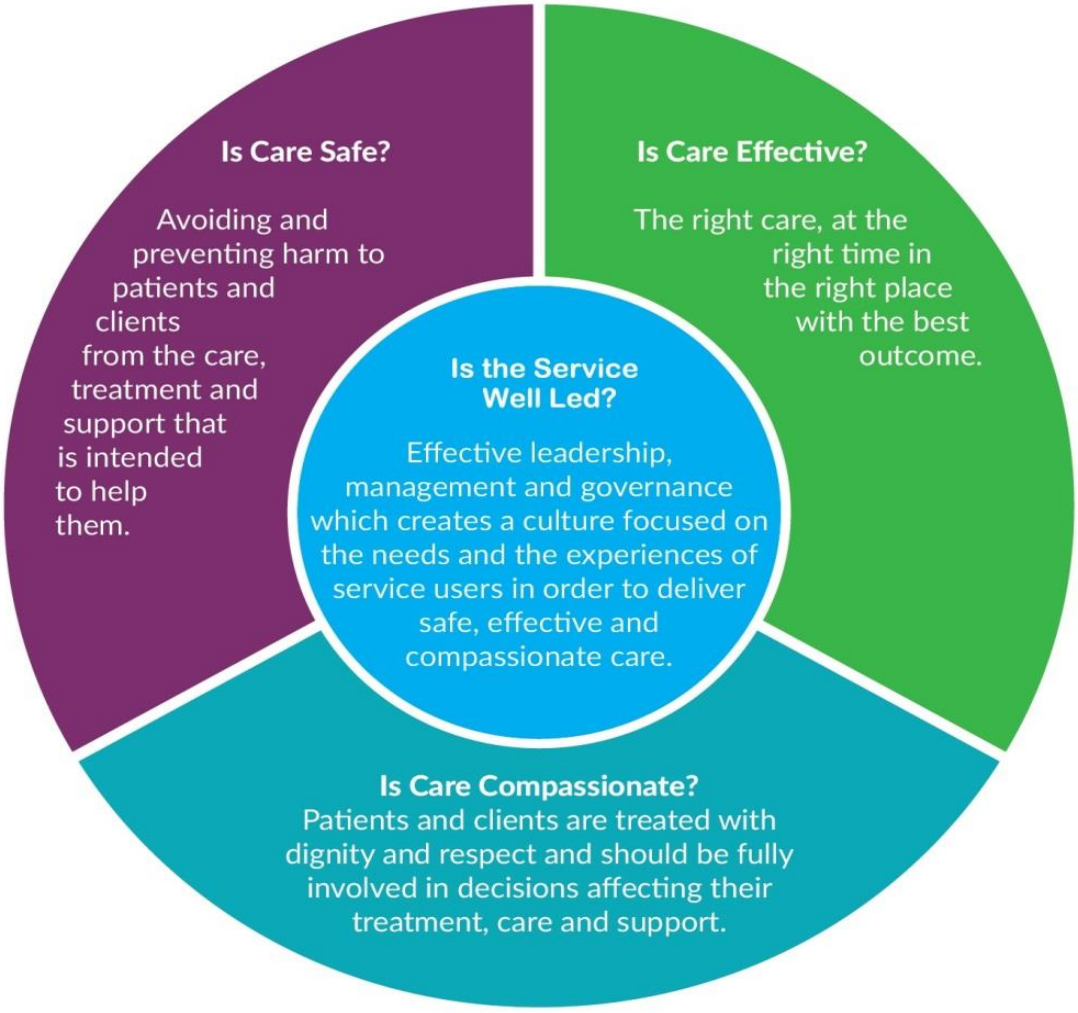
Unannounced Medicines Management Inspection Report
8 May 2018

Edgewater

Type of Service: Nursing Home
Address: 70 Victoria Road, Newbuildings, Londonderry, BT47 2RL
Tel No: 028 7134 2090
Inspector: Judith Taylor

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for



2.0 Profile of service

This is a registered nursing home which provides care for up to 28 persons.

3.0 Service details

Organisation/Registered Provider: Edgewater **Responsible Individual(s):** Mr Paul Steele & Mr Michael Curran	**Registered Manager:** Mr John Green
Person in charge at the time of inspection: Mr John Green	**Date manager registered:** 14 December 2007
Categories of care: Nursing Homes (NH): I – Old age not falling within any other category	**Number of registered places:** 28

4.0 Inspection summary

An unannounced inspection took place on 8 May 2018 from 10.25 to 15.40.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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.

The inspection assessed progress with any areas for improvement identified during and since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to training, competency assessment, the administration of medicines, the completion of medicine records, medicines storage and the management of controlled drugs.

Areas for improvement were identified in relation to the management of new patient's medicines and the management of high risk medicines.

Patients spoke positively about the management of their medicines and their care in the home. They were complimentary about the staff. They were observed to be relaxed and comfortable in the home.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	*2

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mr John Green, 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.

4.2 Action/enforcement taken following the most recent care inspection

Following the most recent inspection on 10 February 2018, a serious concerns meeting was held in RQIA on 15 February 2018 in relation to premises issues. A further inspection to monitor progress is planned.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

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

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection we met with two patients, two staff and the registered manager.

Ten questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

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

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 10 February 2018

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 the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 25 October 2017

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 28 **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that two staff were involved in transcribing of medicine entries on the personal medication records and medication administration records.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** Second time	The procedures to audit the management of medicines should be reviewed to ensure that they cover all areas of medicines management.	**Met**
	Action taken as confirmed during the inspection: A new auditing system had been developed and implemented. This included a variety of medicine formulations, review of records and the QIP from the last medicines management inspection.	

Area for improvement 3 **Ref**: Standard 28 **Stated:** First time	The registered person shall review the patient admission process to ensure that written confirmation of the medicine regime is obtained and checked to ensure all medicines are supplied.	**Partially met**
	Action taken as confirmed during the inspection: We reviewed the admission process in relation to medicines management. Satisfactory arrangements were observed for one patient; however, there was incomplete information for the other two patients. Once this was highlighted, staff began to address this at the inspection. The registered manager advised that this area for improvement had been addressed with staff and the expected practice had been discussed. This area for improvement has been stated for a second time.	
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that a record of all incoming medicines is fully and accurately maintained.	**Met**
	Action taken as confirmed during the inspection: Records of the receipt of medicines were maintained for each of the medicines selected for examination.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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. A sample of training and competency records was provided.

The management of new patients' medicines was reviewed. See also Section 6.2. For one patient, we found that there was a written list of the medicines; however, some of the medicines were not supplied and it was not clear if this had been followed up with the prescriber. One

supplied medicine was not on the list of medicines and it was not clear if and when this was to be administered. These issues were clarified during the inspection and no doses had been missed. In relation to another patient, there was no evidence that the medicines had been verified with the prescriber at or following admission. This was discussed in relation to the safe management of new patient's medicines and that this issue had been raised at the last medicines management inspection. An area for improvement has been stated for a second time.

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. One medicine was out of stock; we were informed that this had been identified and stock was expected later on the day of the inspection. Antibiotics and newly prescribed medicines had been received into the home without delay.

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.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed.

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.

The management of high risk medicines was examined e.g. warfarin and insulin. Written confirmation of the warfarin dosage regime was not obtained for one patient and there was no written confirmation of the changes in insulin doses for two patients. These had been taken by telephone call by one registered nurse. In relation to one insulin dose, incomplete details were recorded. In accordance with safe practice, written confirmation of dosage changes should be in place and/or two staff should witness telephone calls to verify the dose. It was noted that the insulin doses were recorded as 'IU'. Staff were advised that this abbreviation was no longer in use and to promote the safe administration of medicines, the term 'units' should be used. These observations were discussed with staff and the registered manager; an area for improvement was identified.

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. The medicine refrigerator and oxygen equipment were checked at regular intervals. It was agreed that a record of the oxygen checks would be maintained.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of controlled drugs and the storage of medicines.

Areas for improvement

Robust arrangements should be put in place for the management of high risk medicines.

An area for improvement under standards in relation to the management of new patients' medicines has been stated for a second time.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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 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. A care plan was 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. These medicines were infrequently required. Staff were reminded that the reason for and outcome of the administration should be recorded on each occasion.

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 fluid consistency. Records of administration, 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. A small number of the personal medication records needed to be updated and this was addressed at the inspection.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for analgesic medicines and spot checks on medicines which were not supplied in the 28 day blister packs. In addition, a quarterly audit was completed by the community pharmacist.

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

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The administration of medicines to patients was not observed during this inspection. Following discussion with staff it was confirmed that patients were given time to take their medicines and medicines were given in accordance with the patients' preferences.

Throughout the inspection, it was found that there were good relationships between the staff and the patients. Staff were noted to be friendly. It was clear from discussion and observation of staff, that they were familiar with the patients' likes and dislikes.

We met with two patients, who expressed their satisfaction with the care and the staff. They advised that they were administered their medicines on time and any requests e.g. for pain relief, were adhered to. Comments included:

"I am happy here."
"They (staff) know me and what I like."
"I don't have any pain."
"The staff have helped me."
"The food is nice."

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.

Of the questionnaires which were left in the home to receive feedback from patients and their representatives, two were returned with the specified time frame (two weeks). The responses indicated that they were very satisfied with the care in the home. Two comments were made:

"I expect nothing more, very good."
"Staff helpful."

Any comments from patients and their representatives in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas of good practice

Staff listened to patients and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The inspector discussed arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The manager advised that arrangements were in place to implement the collection of equality data within Edgewater.

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.

The management of medicine related incidents was examined. There were systems in place to identify and report incidents. Staff advised of the systems to ensure that they were made aware of incidents to prevent any recurrence. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

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 registered manager and 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 through team meetings, supervision or individually with staff. They advised that management were open and approachable and willing to listen; and stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

No online questionnaires were completed by staff within the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

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

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 28 **Stated:** Second time **To be completed by:** 8 June 2018	The registered person shall review the patient admission process to ensure that written confirmation of the medicine regime is obtained and checked to ensure all medicines are supplied. Ref: 6.2 & 6.4
	Response by registered person detailing the actions taken: Staff made aware of written confirmation required on admission. Written confirmation to be checked. Recording of obtained medicines also checked. Notice in place and follow up checks in place.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 8 June 2018	The registered person shall review the management of high risk medicines to ensure that robust arrangements are in place. Ref: 6.4
	Response by registered person detailing the actions taken: Review of high risk management medication done documentation/record sheets reformated; recorded meds and confirmation of changed doses by telephoned requiring two staff in place.

Please ensure this document is completed in full and returned via the Web Portal

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