Unannounced Medicines Management Inspection Report
25 October 2017

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 nursing home with 28 beds that provides care for elderly patients.

3.0 Service details

Organisation/Registered Provider: Edgewater **Responsible Individuals:** Mr Michael Curran & Mr Paul Steele	**Registered Manager:** Mr John Green
Person in charge at the time of inspection: Ms Amy White (Nursing Sister) until 11.30 and Mr John Green thereafter	**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 25 October 2017 from 10.35 to 15.55.

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.

Overall, there was evidence of good practice in relation to medicines management; this included training and competency, administration of most medicines, the overall standard of record keeping and care planning and the management of controlled drugs.

Areas requiring improvement were identified in relation to auditing arrangements for medicines management, management of medicine changes and new patient's medicines and receipt of medicines records.

Patients were complimentary regarding the management of their medicines. A few comments regarding care delivery were made. See Section 6.6.

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	*4

* the total includes two areas for improvement which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mr John Green, Registered Manager and Ms Amy White, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 15 August 2017. Enforcement action did not result from the findings of this inspection.

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 management of medicine related incidents 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, one care assistant, the nursing sister and the registered manager.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

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 15 August 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was 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 3 May 2016

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:** First time	The necessary arrangements should be made to ensure that only one supply of the patient's medicines is stored on the medicine trolley.	**Met**
	Action taken as confirmed during the inspection: The stock control of medicines had been reviewed. Only one supply of the patient's medicine was stored on the medicine trolley.	

Area for improvement 2 **Ref**: Standard 28 **Stated:** First 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.	**Partially met**
	Action taken as confirmed during the inspection: There was evidence that two staff were routinely involved in the writing and updating of personal medication records. However, this was not observed for the completion of handwritten medication administration records. This area for improvement has been stated for a second time.	
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of four patients' records indicated that a care plan regarding the management of distressed reactions was in place. These medicines were rarely required to be administered. Staff confirmed they were aware that the reason for and outcome of any administration should be recorded on each occasion. However, for one recent administration, this had not been recorded. Staff provided details at the inspection and confirmed that this was the expected practice and was an oversight. This was further discussed and advice given. It was agreed that this would be reviewed with staff. Given these assurances this area for improvement has been assessed as met.	

Area for improvement 4 **Ref**: Standard 28 **Stated:** First time	Two members of trained staff should be involved in the disposal of medicines and both staff should sign the record of disposal.	**Met**
	Action taken as confirmed during the Examination of the medicines records indicated that two staff were routinely involved in the disposal of medicines; both had signed the medicine entry.	
Area for improvement 5 **Ref**: Standard 28 **Stated:** First time	The procedures to audit the management of medicines should be reviewed to ensure that they cover all areas of medicines management.	**Not met**
	Action taken as confirmed during the inspection: There was no evidence that the auditing process had been further developed to cover all areas of medicines management. The internal audit trails continued to focus on medicines supplied in the monitored dosage system. Discrepancies were found in some of the audits completed on medicines which were not supplied in the monitored dosage system and areas for improvement were identified in other areas of medicines management as detailed in the report. This area for improvement has been stated for a second time.	

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. A sample of records was provided. Refresher training in medicines management, palliative care and swallowing difficulty was provided in the last year.

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 provided in August and September 2017.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses, which is considered safe practice. However, this did not occur for any of the updates to handwritten medication administration records. This has been raised at the previous medicines management inspection and the area for improvement has been stated for a second time. See Section 6.2.

The procedures in place to ensure the safe management of medicines during a patient's admission to the home should be reviewed. There was no evidence that written confirmation of one patient's medicine regime had been confirmed with the prescriber at the time of admission and was discussed in relation to ensuring that all prescribed medicines had been supplied. This was highlighted to staff and the prescriber was contacted during the inspection. An area for improvement was identified.

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 e.g. warfarin and insulin was reviewed. A care plan was maintained. Staff were reminded that obsolete warfarin dosage regimes should be securely archived.

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 tidy and organised. The temperatures of medicines storage areas were monitored and recorded on a daily basis. In relation to limited shelf life medicines, the date of opening was not routinely recorded e.g. eye preparations and insulin pen devices. This should be recorded to ensure staff remove and replace the medicine when the expiry date has been reached; they should be included within the audit process. See also Sections 6.2 & 6.7.

The management of oxygen equipment was reviewed. Staff confirmed that checks were completed each week; however, these checks were not recorded. The registered manager advised that this would be commenced with immediate effect. The storage area for oxygen cylinders was discussed in relation to suitability. They were stored in the sluice room. The registered manager was contacted by RQIA on 27 October 2017 and advised to relocate full or in use oxygen cylinders to a more suitable area. He confirmed that this would be addressed.

Areas of good practice

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

Areas for improvement

One area for improvement under standards has been stated for a second time in relation to medicine changes.

The procedures for the management of new patient's medicines should be reviewed to ensure that written confirmation of the current medicine regime is obtained and staff check that all medicines are supplied.

	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.

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. However, discrepancies were noted in the audit trails performed on some medicines which were not supplied in the 28 day monitored dosage system. This included inhaled medicines and liquid medicines. In addition, some audit trails could not be completed as records were incomplete (see below). The auditing arrangements for medicines were raised at the previous medicines management inspection and were further highlighted at this inspection; see also Sections 6.2 & 6.7.

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 an antibiotic was prescribed a care plan was maintained. This is good practice.

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 care plan was maintained. See also Section 6.2.

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. Two patients' records were reviewed. A care plan and speech and language assessment report for each patient was in place. The thickening agent was recorded on one of the personal medication records only; details of the prescribed fluid consistency were not recorded. This was discussed and agreed it would be addressed immediately after the inspection. Separate administration records in the form of fluid intake charts were in use and clearly stated the prescribed fluid consistency.

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. They confirmed that patients were generally compliant with their medicine regimes. It was noted that one inhaled medicine had not been administered in a long time. Following discussion with staff, it was concluded that the patient had refused this inhaler. It could not be ascertained if this had been reported to the prescriber and this was being addressed during the inspection.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the reminder notices regarding medicines management in the treatment room, running stock balances for analgesics and separate administration records for high risk medicines. However, an area for improvement was identified in relation to the receipt of medicines records; when medicines are received in seven day domiciliary packs, a record of each individual medicine must be recorded.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the administration of most medicines, the completion of most records and care planning. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

The procedures for the receipt of medicines should be reviewed to ensure that a full record of all incoming medicines is maintained.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

We observed the administration of medicines at lunchtime. The registered nurse administering the medicines spoke to the patients in a kind and caring manner and the patients were given time to swallow their medicine.

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

The patients spoken to at the inspection, advised that they had no concerns in relation to the management of their medicines, they preferred the registered nurses to administer their medicines and their requests for medicines prescribed on a 'when required' basis were adhered to e.g. pain relief. They were complimentary regarding staff and management. Comments included:

"They (staff) are very good to you."
"They (staff) do look after us."
"The food is very nice."

During the conversations with the patients, a few issues in relation to care were raised and shared with the registered manager for his attention and follow up. They were also shared with the care inspector.

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 facilitate feedback from patients, their representatives and staff, five were returned from patients, one from a patient's representative and two from staff. The responses indicated that they were very satisfied/satisfied with all aspects of the care in relation to the management of medicines.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the listening to and taking account of the views of patients.

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.

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, that incidents were shared with them and new procedures were implemented as deemed necessary, and were aware that medicine related incidents may need to be reported to the safeguarding team.

The auditing process for medicines management was reviewed. Whilst it was acknowledged that there are daily and weekly audits and any discrepancies are highlighted and addressed, these do not include all formulations of medicines and this process has not identified the areas for improvement noted at the inspection. The inspection findings indicate that there are areas for improvement in relation to medicines which are not supplied in the monitored dosage system and in the domains of safe and effective care. The area for improvement in relation to audit has been stated for a second time. See Section 6.2.

Not all of the areas for improvement made at the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

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 management were open and approachable and willing to listen. They also stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

Areas of good practice

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

Areas for improvement

No new areas for improvement were identified.

An area for improvement under standards in relation to auditing of medicines management has been stated for a second time.

	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 and Ms Amy White, Nursing Sister, 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 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:** 26 November 2017	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. Ref: 6.2 & 6.4
	Response by registered person detailing the actions taken: This has been put in place with a new audit sheet to monitor compliance.
Area for improvement 2 **Ref**: Standard 28 **Stated:** Second time **To be completed by:** 26 November 2017	The procedures to audit the management of medicines should be reviewed to ensure that they cover all areas of medicines management. Ref: 6.2 & 6.7
	Response by registered person detailing the actions taken: This has been imeediately reviewed. New audit sheets in place inclusive of all meds .
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 26 November 2017	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: 6.4
	Response by registered person detailing the actions taken: This has been reviewed with a check list in place to ensure same is checked on admission..
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 26 November 2017	The registered person shall ensure that a record of all incoming medicines is fully and accurately maintained. Ref: 6.5
	Response by registered person detailing the actions taken: This has been reviewed and is now part of a check list, reviewed check list.

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

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