Unannounced Medicines Management Inspection Report
11 April 2016

Parkview House

Address: Parkview Road, Castlederg, BT81 7XH
Tel No: 028 81679192
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Parkview House took place on 11 April 2016 from 09.30 to 12.45.

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.

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 Mrs Davina McAllister, Registered 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 8 September 2015.

2.0 Service details

Registered organisation/registered person: Apex Housing Association/ Mr Gerald Kelly	**Registered manager:** Mrs Marion Davina McAllister
Person in charge of the home at the time of inspection: Mrs Marion Davina McAllister	**Date manager registered:** 1 April 2005.
Categories of care: NH-PH, NH-PH(E), NH-I	**Number of registered places:** 15

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

Prior to the inspection, it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with three residents, the registered manager and one registered nurse.

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 8 September 2015

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

4.2 Review of requirements and recommendations from the last medicines management inspection dated 3 June 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 29 **Stated:** First time	It is recommended that the registered person should ensure the reason for and outcome of administration of a medicine prescribed on a "when required" basis for the management of distressed reactions are always recorded.	**Met**
	Action taken as confirmed during the inspection: The reason for and outcome of administration of a medicine prescribed on a "when required" basis for the management of distressed reactions were recorded.	

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 for registered nurses and for care staff who had been delegated medicine related tasks. Refresher training in medicines management was provided annually. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually.

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 and handwritten entries on medication administration 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 a patient's admission to 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; this was acknowledged as good practice.

Robust arrangements were observed for the management of high risk medicines e.g. insulin and medicines administered via the enteral route.

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. 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

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 registered manager, who agreed to closely monitor the administrations of the medicines. 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 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. The reason for and outcome of administration were recorded. A care plan was maintained and evaluated monthly. 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 and that most of the patients could verbalise any pain. A pain tool was used as needed. A care plan was maintained and evaluated monthly. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable.

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 well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included entries on the personal medication records being signed and verified by two nurses and additional records for insulin.

Practices for the management of medicines were audited throughout the month by the registered manager and nursing staff. Running stock balances had been maintained for analgesics. The dates and times of opening of the medicine containers were recorded in order to facilitate audit; this was acknowledged as good practice.

The care files examined documented visits by other health care professionals involved in the patient's care and the outcome of each visit.

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 their room or in the day room. The nurse administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to take their medication.

Patients advised that they had no issues with the management of their medication.

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 the registered nurse on duty, it was evident that she was familiar with the policies and procedures and that any updates were highlighted to her 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.

A review of the internal audit records indicated that satisfactory outcomes had been achieved.

Following discussion with the registered manager and registered nurse, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

The registered nurse 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

No requirements or recommendations resulted from this inspection.

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

I refer you to page 3 paragraph 2; beginning enforcement action result- I feel this is very misleading in the report as Parkview did not have any requirements or recommendations Davina McAllister Nurse Manager.

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.

The Regulation and Quality Improvement Authority

9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews