Unannounced Medicines Management Inspection Report
4 July 2016

Gillbrooke

Type of Service: Nursing Home
Address: 103 Clabby Road, Fivemiletown, BT75 0QY
Tel No: 028 8952 1888
Inspector: Helen Mulligan

1.0 Summary

An unannounced inspection of Gillbrooke took place on 4 July 2016 from 9:00 to 12:30.

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?

The management of medicines supported the delivery of safe care. Staff administering medicines were trained to do so. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. There were no areas for improvement identified.

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. Three areas for improvement were identified in relation to records of the administration of medicines by care staff, the level of auditing of medicines and the management of medicines prescribed on a "when required" basis for the management of distressed reactions. One requirement and one recommendation made at the previous medicines management inspection were stated for the second time and one additional recommendation was made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely. 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. 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.

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. Please also refer to section, 4.2 and 5.0 of this report.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Hilary Palmer, Nurse in Charge, during the inspection and with Mrs Hazel Latimer, Acting Manager by telephone on 20 July 2016. 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 inspection on 6 January 2016.

2.0 Service details

Registered organisation/registered provider: Mr Robert Alan Gilmore	**Registered manager:**
Person in charge of the home at the time of inspection: Ms Hilary Palmer, Registered Nurse	**Date manager registered:** Mrs Hazel Latimer (Acting)
Categories of care: NH-I, RC-I, NH-PH	**Number of registered places:** 25

3.0 Methods/processes

Prior to inspection the following records were analysed:

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

A poster indicating that the inspection was taking place was displayed on the front door of the home. The poster invited visitors/relatives to speak with the inspector. During the inspection the inspector met with five residents and two members of staff.

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 recommendations from the most recent inspection dated 6 January 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the specialist inspector. This QIP will be validated by the specialist inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 15 April 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: **13(4)** **Stated: Once**	The registered manager must maintain a list of the names and sample signatures and initials of all care staff who have been trained and deemed competent to administer medicines in the home.	**Met**
	Action taken as confirmed during the inspection: A sample signature list was in place and was posted in the treatment room.	
Requirement 2 **Ref**: **13(4)** **Stated: Once**	The registered manager must ensure that records of medicines administered by care staff, including records of the administration of thickening agents and medicines for external use are adequately maintained.	**Not Met**
	Action taken as confirmed during the inspection: Records of the administration of thickening agents were not in place. This requirement is stated for the second time.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: **37** **Stated: Once**	The registered manager should ensure that the level and frequency of auditing of medicines is increased and any further discrepancies noted during audit are investigated, and, where appropriate, reported to RQIA.	**Not Met**
	Action taken as confirmed during the inspection: No medicine audits have been completed in the last six months. This recommendation is stated for the second time.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 2 **Ref**: **37** **Stated: Once**	The registered manager should ensure that an up-to-date medicines reference source is available in the home.	**Met**
	Action taken as confirmed during the inspection: Staff on duty advised they had access up-to-date medicine reference sources, including patient information leaflets.	
Recommendation 3 **Ref**: **37** **Stated: Once**	The registered manager should ensure that, where personal medication records are not signed by the prescriber, a copy of current prescriptions is kept in the home.	**Met**
	Action taken as confirmed during the inspection: Personal medication records had been verified and signed by two designated members of staff and a copy of recent prescriptions was maintained in the home.	
Recommendation 4 **Ref**: **37** **Stated: Once**	The registered manager should review and revise the management of anticoagulant medicines to ensure that separate warfarin administration records are maintained, transcribing involves two members of staff and the daily stock balance of supplies of warfarin is monitored and recorded.	**Met**
	Action taken as confirmed during the inspection: Separate records of the administration of warfarin tablets and daily stock balances had been maintained. Transcribing of doses involved two members of staff.	
Recommendation 5 **Ref**: **37** **Stated: Once**	The registered manager should ensure that written policies and procedures are in place for the management of anticoagulant medicines and thickening agents.	**Met**
	Action taken as confirmed during the inspection: Written policies and procedures for the management of anticoagulant medicines and thickening agents were in place and had been recently updated.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 6 **Ref**: **37** **Stated: Once**	The registered manager should review and revise the management of compliance aids in the home.	**Met**
	Action taken as confirmed during the inspection: Staff on duty confirmed the management of compliance aids had been reviewed following the inspection. Unsealed compliance aids are no longer accepted for patients receiving respite care.	

4.3 Is care safe?

Medicines were managed by staff who have been trained 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. Records of competency assessments with respect to medicines management were not available at the time of the inspection. The acting manager confirmed on 20th July 2016 that staff competency was assessed on a regular basis and records of staff competency assessments were maintained. Records showed that refresher training in medicines management was provided in June 2014. The most recent training was in relation to anaphylaxis, administration of controlled drugs, the management of dementia and the management of diabetes.

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. Two recent incidents of out of stock medicines were noted during the audit. Staff were reminded that arrangements must be in place to ensure service users have a continuous supply of their prescribed 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 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. Staff were reminded that, for infection control purposes, supplies of opened creams and ointments and masks on spacer devices should be kept covered.

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 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, monthly or three monthly medicines were due. Staff were reminded that the date of opening of liquid medicines should be recorded to facilitate the audit process.

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. The reason for and the outcome of administration were not recorded and a care plan was not maintained. This should be addressed. 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 tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment is 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. Care plans and speech and language assessment reports were in place. Records of the administration of thickening agents by care staff were not maintained. A requirement made at the previous medicines management inspection was stated for the second time.

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.

Practices for the management of medicines were not being audited throughout the month by the staff and management. This should be addressed. A recommendation was stated for the second time.

Following discussion with the acting manager and staff, it was evident that when applicable, there was appropriate communication between all healthcare professionals involved in the care of the patients with respect to medicines management.

Areas for improvement

Records of medicines administered by care staff, including records of the administration of thickening agents and medicines for external use must be adequately maintained. A requirement was stated for the second time.

The level and frequency of auditing of medicines should be increased and any further discrepancies noted during audit should be investigated, and, where appropriate, reported to RQIA. A recommendation was stated for the second time.

Where medicines are prescribed on a "when required" basis for the management of distressed reactions, there should be a care plan in place and the reason for and outcome of administration should be recorded on each occasion. A recommendation was made.

Number of requirements	1	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. Patients advised that they had received their medicines that morning and were able to request tablets if they were in pain. Patients advised they were "very comfortable" and "happy with their medicines".

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.

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 and updated in 2016. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

Staff confirmed that they knew how to identify and report incidents. No incidents involving medicines had been reported to RQIA since the last medicines management inspection.

A review of the audit records indicated that largely satisfactory outcomes had been achieved, although no audits had been completed in the last six months. A recommendation regarding the level and frequency of auditing was stated for the second time in Section 4.4 above.

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.

One requirement and one recommendation made at the last medicines management inspection had not been addressed and are stated for the second time in this report. 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.

Staff confirmed that any concerns in relation to medicines management would be raised with management.

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 this QIP were discussed with Ms Hilary Palmer, Nurse in Charge, 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 Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The 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 taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements 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

Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time **To be completed by:** 3 August 2016	The registered manager must ensure that records of medicines administered by care staff, including records of the administration of thickening agents and medicines for external use are adequately maintained.
	Response by registered provider detailing the actions taken: All medicines administered by care staff are recorded. Thickening agents are recorded on food, fluid or specified thickener audit charts. Topical medicines have always been recoded on individual record charts.
Recommendations	
Recommendation 1 **Ref**: Standard 37 **Stated:** Second time **To be completed by:** 3 August 2016	The registered manager should ensure that the level and frequency of auditing of medicines is increased and any further discrepancies noted during audit are investigated, and, where appropriate, reported to RQIA.
	Response by registered provider detailing the actions taken: Trained staff will carry out audits of medicines more frequently and any discrepancies are investigated and reported as appropriate to RQIA.
Recommendation 2 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 3 August 2016	The registered provider should ensure that where medicines are prescribed on a "when required" basis for the management of distressed reactions, a care plan is in place and the reason for and outcome of administration is recorded on each occasion.
	Response by registered provider detailing the actions taken: Care Plans are in place for when required medicines and when given the reason and outcome recorded on evaluation sheets.

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

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