Unannounced Medicines Management Inspection Report
18 October 2017

Gillbrooke

Type of Service: Nursing Home
Address: 107 Clabby Road, Fivemiletown, BT75 0QY
Tel No: 028 8952 1888
Inspector: Frances Gault

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 25 beds that provides care for patients as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Gillbrooke Care Centre Ltd **Responsible Individual:** Mr John James Wesley Kerr	**Registered Manager:** See box below.
Person in charge at the time of inspection: Ms Dorothy Gilmore, Registered Nurse	**Date manager registered:** Mrs Hazel Latimer - Acting – No application required
Categories of care: Nursing Home: I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH (E) – Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 25 This home is also approved to provide care on a day basis for up to 3 persons.

4.0 Inspection summary

An unannounced inspection took place on 18 October 2017 from 09.55 to 12.55.

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.

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

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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 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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Dorothy Gilmore, Registered Nurse, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions required to be taken following the most recent inspection on 19 June 2017.

5.0 How we inspect

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

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

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector.

During the inspection we met with one patient individually and several sitting in a lounge, a care assistant and two registered nurses.

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
- care plans
- training records
- medicines storage temperatures

Areas for improvements 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 19 June 2017

The most recent inspection of the home was an unannounced post registration 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 4 July 2016

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: The evidence seen during the inspection identified that separate administration records were in place for completion by care staff when they administered external preparations. The administration of thickening agents was recorded by registered nurses on the medicine administration records and when appropriate by care staff on fluid charts. The directions were detailed on the fluid charts.	

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 37 **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: Regular audits were undertaken and the outcomes documented. No discrepancies had been noted which required to be reported to RQIA.	
Area for improvement 2 **Ref**: Standard 18 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Care plans were in place which were reviewed regularly. It was noted that the reason for and the outcome was not always recorded. It was agreed with the manager that this would be addressed. Given this assurance this area for improvement was assessed as met.	

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 and supervision. Competency assessments were completed annually. Refresher training in syringe drivers and dysphagia awareness was provided in the last year.

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. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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 this year.

There were procedures in place to ensure the safe management of medicines during a patient's admission to 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.

Robust arrangements were observed for the management of high risk medicines e.g. insulin.

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. The monthly supplies of medicines had just been received into the home and it was noted that space is limited. The need for additional storage should be kept under review. 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 of good practice

There were examples of good practice found throughout the inspection in relation to staff training, supervision, the management on medicines on admission/discharge and the storage of prescriptions and medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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, monthly 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, specific 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. The reason for and the outcome of administration were not always documented. This was discussed and it was agreed that all staff would be reminded of the expected practice. It was noted that one patient was receiving their "when required" medicine regularly. It was agreed that this would be discussed with the prescriber (see 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 tool was used as needed. A care plan was maintained.

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. Each administration was recorded and care plans and speech and language assessment reports were in place (see Section 6.2).

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 recording the date of opening of a supply on the medicine administration records.

Practices for the management of medicines were audited throughout the month by the staff and management.

Following discussion with the staff, it was evident that when applicable, other healthcare professionals are contacted in response to the health care needs of the patients.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to care records, audits and reviews, communication between patients, staff and other key stakeholders.

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 being completed at the start of this inspection and was not observed. Staff were knowledgeable about the administration of medicines.

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 and were heard knocking on bedroom doors prior to entering. It was clear from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes.

Of the questionnaires that were issued, two were returned from relatives and four from staff. The responses indicated that they were very satisfied/very satisfied with all aspects of the care in relation to the management of medicines. Staff in their responses confirmed that only nurses administer medicines.

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

One patient spoken with during the inspection advised that "the staff are wonderful".

Areas of good practice

Staff listened to residents and account of their views. There was a warm and friendly atmosphere.

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 not examined during this inspection.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

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

Following discussion with the 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 of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of medicine incidents, quality improvement and maintaining good working relationships.

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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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