Unannounced Medicines Management Inspection Report
21 November 2016

Silverdale

Type of Service: Nursing Home
Address: 29a Castlegore Road, Castlederg, BT81 7RU
Tel no: 028 8167 9574
Inspector: Helen Mulligan

1.0 Summary

An unannounced inspection of Silverdale took place on 21 November 2016 from 11:30 to 15:30.

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?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. 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. No areas for improvement were identified.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for patients. 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. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. 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.

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 Geraldine Browne, 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 finance inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 11 November 2016.

2.0 Service details

Registered organisation/registered person: SRB Care Limited/Mrs Sarah Roberta Brownlee	**Registered manager:** Mrs Geraldine Browne
Person in charge of the home at the time of inspection: Mrs Geraldine Browne	**Date manager registered:** 10 June 2009
Categories of care: NH-DE, NH-I, NH-PH	**Number of registered places:** 41

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.

We met with three patients, one senior carer, two registered nurses, the registered manager and two patients' relatives.

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 11 November 2016

The most recent inspection of the home was an unannounced finance inspection. The report of this inspection was issued to the home on 22 November 2016 and the completed QIP is to be returned to RQIA by 20 December 2016.

4.2 Review of requirements and recommendations from the last medicines management inspection 27 October 2014

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must ensure that home staff denature controlled drugs prior to their disposal.	**Met**
	Action taken as confirmed during the inspection: Records showed that controlled drugs were denatured prior to disposal.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should review and revise systems for auditing and monitoring medicines to ensure they include a selection of all medicines in the home.	**Met**
	Action taken as confirmed during the inspection: Improved auditing arrangements were noted to be in place. Running stock balances of medicines prescribed on a "when required" basis were maintained. "End of box" audits were completed for each medicine. The registered manager completes an audit of medicines management in the home on a three monthly basis.	

Recommendation 2 **Ref**: Standard 37 **Stated:** First time	The registered manager should review and revise the management of medicines prescribed on an "as required" basis for the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: Care plans for the management of distressed reactions and the administration of medicines were in place. Staff have recorded why each dose of medicine was required to be administered and the noted effect.	

4.3 Is care safe?

Medicines were managed by members of 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 have 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 May 2016. The most recent training was in relation to the management of Parkinson's and the management of dementia.

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 were signed by the prescriber.

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, insulin and medicines administered through enteral feeding tubes. The use of separate administration charts was acknowledged.

Appropriate arrangements were in place for administering medicines in disguised form.

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. 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. The registered manager was reminded that all oxygen cylinders should be chained to the wall when not in use.

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 and three/six 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. 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 recorded. A care plan was maintained.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that on-going monitoring was necessary to ensure that pain was well controlled and the patient was comfortable. Staff advised that some of the patients could verbalise any pain, and a pain tool was used as needed. A care plan was maintained for the majority of patients reviewed. Following the inspection, the registered manager confirmed by email on 22 November 2016 that all care plans for the management of pain had been reviewed and, where necessary, updated. 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. Each administration was recorded and 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.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the maintenance of running stock balances for medicines administered on a "when required" basis.

Non-prescribed medicines (home remedies) were managed appropriately.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines, nutritional supplements and inhaled medicines. In addition, a quarterly audit was completed by the registered manager.

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

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 patients was completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible. Patients were offered pain relief during the lunchtime medicine round.

Patients advised:

- “I got my medicines today.”
- “I am happy enough here.”
- “I have no problems. I would ask for a pain tablet if needed.”

Relatives advised:

- “I am very happy.”
- “I am very happy with my mother’s care. The manager here is one in a million.”

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. Staff knew the patients’ preferences regarding the administration of medicine and food choices.

Ten staff questionnaires, 10 relative/visitor questionnaires and five questionnaires for patients were left in the home to facilitate feedback from staff, patients and relatives/visitors. One relative’s questionnaire was returned and the respondent advised they were very satisfied with the care provided with respect to medicines management.

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. Management advised that these were subject to regular review. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

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. There was evidence of the action taken and learning implemented following incidents.

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, registered nurses and care staff, it was evident that members of staff were familiar with their roles and responsibilities in relation to medicines management.

The requirements and recommendations made at the last medicines management inspection have been addressed.

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

The registered manager advised that updates are provided for relatives at regular relatives' meetings in the home. A palliative care nurse specialist has been invited to speak at the next relatives' meeting on 30 November 2016. This good practice was acknowledged.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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