Unannounced Medicines Management Inspection Report

16 September 2016

Springlawn

Type of Service: Nursing Home
Address: 44 Old Dromore Road, Omagh, BT78 1RB
Tel No: 028 8224 4550
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of Springlawn took place on 16 September 2016 from 10.40 to 13.45.

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.

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. There were no areas of 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. There were no areas of improvement 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 of 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 of 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.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Sylvia Ewart, Nurse in Charge, 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.

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 most recent inspection on 7 July 2016.

2.0 Service details

Registered organisation/registered person: Ms Bernadette Kiernan O'Donnell	**Registered manager:** Ms Sharon Margaret Colhoun
Person in charge of the home at the time of inspection: Mrs Syliva Ewart, Nurse in Charge	**Date manager registered:** 01 April 2005
Categories of care: NH-LD(E), NH-PH, RC-PH, RC-I, NH-I, NH-PH(E)	**Number of registered places:** 40

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home

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 two residents, one care assistant and two registered nurses.

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. No one availed of this opportunity during the inspection.

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
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 July 2016

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

4.2 Review of requirements and recommendations from the last medicines management inspection dated 30 May 2013

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	Prescriptions should be received into the home and checked before dispensing.	**Met**
	Action taken as confirmed during the inspection: The nurse in charge advised that prescriptions are received by the home, checked and photocopied prior to dispensing.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. Staff advised that an induction process was in place for registered nurses. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in the management of PEG tubes, syringe drivers and general medicines management had been provided since the last inspection.

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 and discharge from the home. The admission procedure in relation to patients who regularly receive respite care was discussed. Staff were reminded that any changes to prescribed medicines between periods of respite should be confirmed in writing by the general practitioner.

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. Staff were reminded that insulin pens and eye drops should be marked with the date of opening so that the date of expiry can be determined. 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 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, 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 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.

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 extra records for monitoring fluid intake and the administration of food supplements.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicines.

Following discussion with the registered manager and staff, it was evident that, other healthcare professionals are contacted when necessary to meet the needs of the 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 several patients was observed during the inspection. The nurse administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to swallow each medicine. Extra time and attention was given to patients who had difficulty swallowing some of the medicines. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients were treated courteously, with dignity and respect. Good relationships were evident.

The patients spoken to said that they had no concerns in relation to the management of their medicines.

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 and standard operating procedures for the management of controlled drugs were in place.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. There have been no medicine related incidents since the last medicines management inspection.

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 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 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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