Unannounced Medicines Management Inspection Report
29 September 2016

Fruithill Nursing Home

Type of Service: Nursing Home
Address: 20 Fruithill Park, Andersonstown, Belfast, BT11 8GD
Tel no: 028 9061 7717
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Fruithill Nursing Home took place on 29 September 2016 from 09.50 to 14.10.

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. Some systems in place to ensure the management of medicines was in compliance with legislative requirements and standards should be further developed. One recommendation was stated for a second time and four further recommendations were made regarding medicine records, the destruction and disposal of medicines and the cold storage of medicines.

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. One area of improvement was identified in relation to the records maintained for medicines prescribed on a 'when required' basis for distressed reactions. A recommendation was stated for a second time.

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. The patient 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 have been well led with respect to the management of medicines. These standards had been satisfactorily maintained during a series of changes in management in the home. 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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	6

Details of the Quality Improvement Plan (QIP) within this report were discussed with Miss Veronica Sousa, Manager, 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 18 May 2016.

2.0 Service details

Registered organisation/registered person: Ms Orla Frances Sheehan	**Registered manager:** see below
Person in charge of the home at the time of inspection: Miss Veronica Sousa (incoming manager - no application received)	**Date manager registered:** Ms Thresia Paily (acting - no application required)
Categories of care: NH-LD, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 35

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 one patient, one registered nurse, the new manager and the acting manager.

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
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 18 May 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and was 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 20 July 2015

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time	The registered person must confirm that the specified patients have a supply of their prescribed medicines available for administration.	**Met**
	Action taken as confirmed during the inspection: It was confirmed following the inspection that the relevant medicines were received on 20 July 2015.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 29 **Stated:** First time	It is recommended that the record of disposed medicines is signed by the nurse responsible for the disposal and a second witness to the disposal.	**Not Met**
	Action taken as confirmed during the inspection: This was not evidenced in records for the last few months examined, with the exception of those for some controlled drugs in recent weeks. **This recommendation was restated.**	

Recommendation 2 **Ref:** Standard 28 **Stated:** First time	It is recommended that the policies and procedures for the management of medicines are reviewed and, where necessary, revised to ensure that they are still appropriate	**Met**
	Action taken as confirmed during the inspection: The policies and procedures for the management of medicines had been reviewed and revised in October 2015. There was evidence that these had been shared with registered nurses.	
Recommendation 3 **Ref:** Standard 18 **Stated:** First time	It is recommended that the management of medicines prescribed on a "when required" basis for the management of distressed reactions is reviewed and revised to ensure that all of the appropriate records are maintained.	**Partially Met**
	Action taken as confirmed during the inspection: The management of these medicines had been reviewed and care plans were in place for two of three records examined. A care plan detailing the use of these medicines should be in place for all relevant patients. The reason for and outcome of the administration of these medicines was recorded on some occasions in the care notes, this should be documented on every occasion. **This recommendation was restated.**	

4.3 Is care safe?

Staff and management confirmed that there was an induction process for registered nurses, agency nurses and care staff who had been delegated medicine related tasks. This was evidenced for the two registered nurses on duty. Medicines were managed by staff who have been trained and deemed competent to do so. The new manager stated that she intended to monitor the impact of training through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management, provided by the community pharmacist, was arranged for early October 2016. The most recent training was in relation to palliative care, dementia and anaphylaxis.

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.

The arrangements in place to manage changes to prescribed medicines were examined. Personal medication records were updated by two registered nurses. Handwritten entries on medication administration records were not always signed and verified by a second designated member of staff to ensure accuracy in transcribing. A recommendation was made.

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 spot 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.

Discontinued or expired medicines were mostly disposed of appropriately. Most discontinued controlled drugs subject to safe custody were denatured and rendered irretrievable prior to disposal. However, for one Schedule 3 controlled drug (tramadol) and some Schedule 4 (Part 1) controlled drugs; there was no evidence in records of these medicines being denatured before disposal. It was recommended that the destruction of these controlled drugs is reviewed to ensure that this takes place on every occasion and is reflected in the records of disposal. The record of disposal of medicines was not signed by the nurse responsible for the disposal and a second designated member of staff to witness the disposal. A recommendation made at the last medicines management inspection was stated for a second time.

Medicines were largely stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean and tidy. However, the date of opening of medicines was not always recorded. This should be recorded on all medicines to facilitate audit and to alert staff of the expiry dates of medicines with a limited shelf life once opened. This should include eye preparations, insulin pen devices in use and blood glucose monitor control solutions. A recommendation was made.

Medicine refrigerators and oxygen equipment were checked at regular intervals. Medicine storage temperatures were satisfactory at the time of the inspection. However, records indicated that the temperature of the medicines refrigerator had sometimes fallen below the accepted range for the cold storage of medicines (2-8°C) in recent months. Records indicated that the thermometer was not being reset according to the operating instructions. The cold storage of medicines should be reviewed to ensure that the temperature remains in the required range at all times and any variation is escalated to management for further action. A recommendation was made.

Areas for improvement

Handwritten entries on medication administration records should be signed and be verified by a second designated member of staff to ensure accuracy in transcribing. A recommendation was made.

The destruction and disposal of Schedule 3 and Schedule 4 (Part 1) controlled drugs should be reviewed to ensure that these medicines are denatured prior to disposal on every occasion and that this is reflected in the records of disposal. A recommendation was made.

Records of the disposal of medicines should be signed by the nurse responsible for the disposal and a second designated member of staff to witness the disposal. A recommendation was stated for a second time.

The date of opening should be recorded on all medicines to facilitate audit and to alert staff of the expiry dates of medicines with a limited shelf life, once opened. A recommendation was made.

The cold storage of medicines should be reviewed to ensure that the temperature remains in the required range at all times and any variation is escalated to management for further action. A recommendation was made.

Number of requirements	0	Number of recommendations	5

4.4 Is care effective?

The sample of medicines examined had been administered in accordance with the prescriber's instructions. 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. A care plan was maintained for two of the three records examined. 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 always recorded, although the administration of these medicines was recorded on a separate record. The management of distressed reactions should be reviewed. A recommendation made at the last medicines management inspection was stated for a second time.

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 the patients could verbalise any pain. A care plan was maintained in the majority of the records examined, the manager was aware of this and agreed to ensure a care plan was in place for all relevant patients. 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 prescribed fluid consistency. Each administration was recorded and care plans and speech and language assessment reports were in place.

The management of enteral feeding was examined and the records examined had been completed in a satisfactory manner.

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 completion of transdermal patch application and removal records and separate warfarin and insulin administration records.

Practices for the management of medicines were audited throughout the month by the staff and management. Running stock balances were maintained for several medicines including antibiotics, inhaled medicines and analgesics prescribed for use 'when required'. In addition, a quarterly audit was completed by the community pharmacist. The new manager stated that she intends to review the systems for audit in the coming months.

Following discussion with the manager and staff, it was evident that when applicable, other healthcare professionals were contacted regarding the management of medicines.

Areas for improvement

The management of medicines prescribed on a "when required" basis for the management of distressed reactions should be reviewed and revised to ensure that all of the appropriate records are maintained. A recommendation was stated for a second time.

Number of requirements	0	Number of recommendations	1

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.

The patient spoken to advised that they were satisfied with the manner in which their medicines were managed and administered. They were complementary about the staff and their care in the home.

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 were updated and shared with staff in October 2015.

There were 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 manager and registered nurses, 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. They advised that any resultant action was communicated at handover and at team meetings.

Not all of the recommendations made at the last medicines management inspection had been addressed effectively. 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.

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 the QIP were discussed with Miss Veronica Sousa, Manager, 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 The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and 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 to be taken by the registered provider

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

Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** Second time **To be completed by:** 29 October 2016	It is recommended that the record of disposed medicines is signed by the nurse responsible for the disposal and a second witness to the disposal.
	Response by registered provider detailing the actions taken: Nursing staff have been advised of disposal of medicines procedure must be witnessed and signed accordingly.
Recommendation 2 **Ref**: Standard 18 **Stated:** Second time **To be completed by:** 29 October 2016	It is recommended that the management of medicines prescribed on a "when required" basis for the management of distressed reactions is reviewed and revised to ensure that all of the appropriate records are maintained.
	Response by registered provider detailing the actions taken: New template for administration of medicines for distressed reactions and evaluation of medicines' effectiveness developed and implemented on 29.09.16.
Recommendation 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 29 October 2016	The registered provider should ensure that handwritten entries on medication administration records are signed and are verified by a second designated member of staff to ensure accuracy in transcribing.
	Response by registered provider detailing the actions taken: Nursing staff have been informed of requirements for handwritten entries onto medicines administration records with regular audit of this practice by Nurse Management Team.
Recommendation 4 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 29 October 2016	The registered provider should ensure that the destruction and disposal of Schedule 3 and Schedule 4 (Part 1) controlled drugs is reviewed to ensure that these medicines are denatured prior to disposal on every occasion and that this is reflected in the records of disposal.
	Response by registered provider detailing the actions taken: Schedule 3 and Schedule 4 (Part 1) controlled drugs denatured using denaturing kit in controlled drugs cupboard with appropriate record keeping, as in keeping with the Home Policy on Disposal of Controlled Drugs. All nursing staff have been advised of requirement for destruction and disposal of controlled drugs.

Recommendation 5 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 29 October 2016	The registered provider should ensure that the date of opening is recorded on all medicines to facilitate audit and to alert staff of the expiry dates of medicines with a limited shelf life once opened.
	Response by registered provider detailing the actions taken: Staff reminded that date of opening must be recorded on all medicines including eye drops and inhalers and that this is also to alert them of expiry dates of medicines with a limited shelf life. This is monitored in the monthly medicines audit.
Recommendation 6 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 29 October 2016	The registered provider should ensure that the cold storage of medicines is reviewed to ensure that the temperature remains in the required range at all times and any variation is escalated to management for further action.
	Response by registered provider detailing the actions taken: Fridge temperature being reset daily to ensure temperature is within range and this is also included in monthly audit checks. Nursing staff advised that any variations in temperature to be reported to Nurse Manager, Sister in Charge or Nurse in charge for the shift. Medicines Policy amended to include daily resetting of fridge and fridge temperature checks template updated and posted beside fridge.

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