Unannounced Medicines Management Inspection Report
15 June 2016

Parkview

Type of Service: Nursing Home
Address: Glencairn Road, Forthriver Road, Belfast, BT13 3PU
Tel No: 028 9039 1393
Inspectors: Judith Taylor & Frances Gault

1.0 Summary

An unannounced inspection of Parkview took place on 15 June 2016 from 09:40 to 14.20

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 were trained and competent and there were robust processes for the stock control of medicines, management of medicines changes and management of high risk medicines. One recommendation in relation to the administration of medicines has been made. No requirements have been made.

Is care effective?

There was evidence that the management of medicines supported the delivery of effective care and positive outcomes for patients. There were systems in place to ensure that the patients were administered their medicines as prescribed. Robust arrangements were in place for the management of pain and dysphagia. Two recommendations in relation to record keeping have been made. No requirements have been made.

Is care compassionate?

There was evidence that the management of medicines supported the delivery of compassionate care. Where possible patients were involved in the management of their medicines and there was evidence of self-administration. Staff interactions with patients were observed to be compassionate, caring and timely, which promoted the delivery of positive outcomes for patients. No requirements or recommendations have been made.

Is the service well led?

There was evidence that the service was well led with respect to the management of medicines. Written medicine policies and procedures were in place. Robust systems for the management of medicine related incidents and the auditing of medicines management were observed. No requirements or recommendations have been made.

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 the DHSSPS Nursing Homes Minimum Standards, February 2008.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	3

Details of the QIP within this report were discussed with Mrs Gillian Finlay, Registered 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 finance inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the most recent inspection on 5 April 2016.

2.0 Service details

Registered organisation/ registered person: Four Seasons Healthcare / Dr Maureen Claire Royston	**Registered manager:** Mrs Gillian Finlay
Person in charge of the home at the time of inspection: Mr Cristian Burduja (Charge Nurse) at the beginning of inspection and Mrs Gillian Finlay for remainder of the inspection.	**Date manager registered:** 18 March 2015
Categories of care: RC-LD(E), NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 71

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 five patients, seven care staff and four registered nurses.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspectors. No one availed of the opportunity.

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 5 April 2016

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

4.2 Review of requirements and recommendations from the last medicines management inspection dated 4 April 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that the record of disposed medicines is signed by the two nurses responsible for the disposal.	**Met**
	Action taken as confirmed during the inspection: There was evidence that two registered nurses were involved in the disposal of medicines.	
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that the receipt of controlled drugs is fully documented in the controlled drugs record book.	**Met**
	Action taken as confirmed during the inspection: Examination of the controlled drug record book indicated that a record of the receipt of controlled drugs had been maintained.	
Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that all controlled drugs subject to safe custody are stored in the appropriate controlled drugs cupboard.	**Met**
	Action taken as confirmed during the inspection: Satisfactory storage arrangements were in place for controlled drugs.	
Requirement 4 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that the refrigerator temperatures are appropriately monitored and recorded daily.	**Met**
	Action taken as confirmed during the inspection: The temperature records for three medicine refrigerators were examined. These indicated that the temperatures were monitored and recorded every day; and were maintained within the accepted temperature range for medicines which require cold storage.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should ensure that further monitoring of liquid medicines and nutritional supplements should be undertaken to ensure that these medicines are being administered in accordance with prescribed instructions.	**Met**
	Action taken as confirmed during the inspection: There was evidence that liquid medicines and oral nutritional supplements were included in the audit process.	
Recommendation 2 **Ref**: Standard 37 **Stated:** First time	The registered manager should ensure that the quantity of analgesics and nutritional supplements carried forward into the next cycle is recorded in order to facilitate the audit process.	**Met**
	Action taken as confirmed during the inspection: This had been reviewed and although the carried forward quantity was not recorded, the system which is now in place facilitates the auditing of these medicines. This includes the maintenance of a separate administration record for both analgesics and nutritional supplements. A running stock balance is maintained for analgesics and there was evidence of stock balance checks of nutritional supplements at periodic intervals per medicine cycle.	

4.3 Is care safe?

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. Training included attendance at training sessions and the completion of training e-learning modules. 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 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.

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.

The management of medicines which were administered in disguised form was examined. Whilst there was evidence of an assessment, there was no care plan in place and it could not be ascertained if the medicines which were crushed/capsule opened were suitable for this method of administration. Where medicines are required to be administered in disguised form, a detailed care plan should be in place which includes evidence of consultation with the prescriber and of the review process in place. Advice should be obtained regarding how the medicines should be administered. A recommendation was made.

The management of medicines administered via an enteral feeding tube was examined. This area of medicines was well managed, however, there was no evidence of authorisation from the prescriber regarding the administration of medicines via this route. The registered manager provided assurances that this would be followed up with the prescriber after the inspection.

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.

Areas for improvement

The management of medicines administered in disguised form should be reviewed. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

The majority of medicines which were audited at the inspection had been administered in accordance with the prescriber's instructions. A small number of discrepancies were observed and discussed with the registered manager and it was agreed that these would be closely monitored. There was evidence that time critical medicines had been administered on time. There were arrangements in place to alert staff of when doses of weekly 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. A care plan was maintained for some patients. The reason for and the outcome of administration were occasionally recorded. 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 stated that most of the patients could advise staff if they were in pain, and a pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment was 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.

A group of care staff spoke knowledgeably about their role in the administration of thickened fluids and were able to demonstrate how this was documented and evaluated. From their comments it was evident that they knew the patients' likes and dislikes.

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 use of separate administration records for a number of medicines.

Some improvement was necessary in the maintenance of personal medication records:

- when a medicine is discontinued the entry should be deleted
- when a prescribed dosage is changed, the original entry should be deleted and a new entry written
- staff should review the record prior to making additional entries to ensure that entries are not duplicated.

A recommendation was made.

The management of medicines was audited throughout the month by the registered nurses and the registered manager. The audits included running stock balances for several solid dosage medicines, liquid medicines and inhaled medicines and review of medicine records and medicine equipment. In addition, a quarterly audit was completed by the community pharmacist. The audit process was readily facilitated by recording the date of opening on medicines.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to issues or concerns in relation to medicines management.

Areas for improvement

The management of distressed reactions should be reviewed to ensure that a detailed care plan is maintained for the relevant patients and the reason for and outcome of any administration is recorded. A recommendation was made.

The standard of record keeping of personal medication records should be closely monitored to ensure they are up to date at all times. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

The arrangements in place for the self-administration of medicines were examined. A record of the transfer of medicines to the patient was in place. Staff advised that there were procedures in place to monitor compliance.

The administration of medicines to patients was observed during the inspection. The staff administered the medicines in a caring manner and patients were given time to take their medicines. There was evidence that medicines were administered in accordance with the patients' preferences in order to maintain dignity and privacy. One registered nurse commented that "every person is special" as she waited for the patient to take her medicines.

Staff were noted to be wearing red tabards to alert staff/visitors that the administration of medicines to the patients must not be disrupted.

The patients spoken to at the inspection stated that they were content with their care in the home and had no concerns regarding the management of their medicines. They advised that staff responded in a timely manner to any requests for medicines e.g. pain relief. They spoke positively about the staff and comments included:

"excellent nurse and staff"
"I am very happy here, they look after me"
"care the best".

The registered manager advised of a recent initiative taken in the home supported by a local general practitioner and community specialist nursing team which had enabled a patient to remain in the home and receive treatment instead of being hospitalised. She hoped that this service would be developed further. This is an example of the delivery of compassionate care.

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. Management advised that these were reviewed every three years. 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.

The registered manager advised that all grades of staff were in the process of completing an 18 week programme - Dementia Care Framework. She explained that this home was one of three pilot homes selected for the completion of this framework. She advised that this involved staff being trained in how the patient experiences dementia including their sensory experience. She provided examples of scenarios completed by staff. In relation to medicines management she advised that this framework detailed the management of distressed reactions, pain and communication. She also stated that this training has resulted in a reduction in the occurrence of distressed reactions in patients. The involvement in initiatives like this indicates that this service is seeking to make positive changes to benefit patients and improve the knowledge and skills of staff.

There was evidence that the auditing processes for medicines management were well embedded into routine practice and outcomes were reviewed on a daily basis by management. A review of the audit records indicated that largely satisfactory outcomes had been achieved. In the instances where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice. The registered manager advised that as part of the governance arrangements within the home, a monthly meeting was held with herself, the deputy manager and the four unit managers. She stated this arrangement promoted consistency of practice throughout the home.

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.

Staff advised that management were open and approachable and willing to listen. They spoke positively about their work and stated that there were good working relationships within the home and with relatives.

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

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated through team meetings and supervision.

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 Mrs Gillian Finlay, Registered 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 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 completed QIP to *pharmacists@rqia.org.uk* for review 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 28 **Stated:** First time **To be completed by:** 15 July 2016	The registered provider should review the management of medicines administered in disguised form.
	Response by registered provider detailing the actions taken: Medicines administered in disguised form have been discussed with the prescriber and care plans have been reviewed and updated
Recommendation 2 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 15 July 2016	The registered provider should review the management of distressed reactions.
	Response by registered provider detailing the actions taken: Care planning in relation to medication for distressed reaction have been reviewed to include the reason for and the expected outcome for administration.
Recommendation 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 15 July 2016	The registered provider should closely monitor the standard of record keeping in relation to personal medication records.
	Response by registered provider detailing the actions taken: All personal medications received are to be recorded. Discussions have taken place with nursing staff to reinforce the importance of this for audit and review.

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