Unannounced Medicines Management Inspection Report
27 September 2017

Parkview

Type of Service: Nursing Home
Address: Glencairn Road, Forthriver River Road, Belfast BT13 3PU
Tel No: 028 9039 1393
Inspector: Judith Taylor

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 71 beds that provides care for patients living with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** Ms Jennifer Watson
Person in charge at the time of inspection: Ms Jennifer Watson	**Date manager registered:** 9 June 2017
Categories of care: Nursing Homes (NH) I – Old age not falling within any other category DE – Dementia PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years TI – Terminally ill Residential Care Homes (RC) LD(E) – Learning disability – over 65 years	**Number of registered places:** 71 including: a maximum of 15 patients in category NH-DE and 1 named resident in category RC-LD(E)

4.0 Inspection summary

An unannounced inspection took place on 27 September 2017 from 10.10 to 16.40.

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 the governance arrangements for medicines, the standard of maintenance of medicine records, the management of controlled drugs and the storage of medicines.

No areas for improvement were identified.

Patients were complimentary regarding the management of their medicines and the care provided in the home.

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 Jennifer Watson, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 30 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:

- 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 poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection we met with four patients, two registered nurses, one care assistant, the deputy manager and the registered manager.

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

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

Areas for improvement 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 30 June 2017

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 the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 15 June 2016

Areas for improvement from the last medicines management inspection		
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 28 **Stated:** First time	The registered provider should review the management of medicines administered in disguised form.	**Met**
	Action taken as confirmed during the inspection: When medicines were required to be administered in disguised form, a care plan was maintained and consent had been obtained from the prescriber.	
Area for improvement 2 **Ref**: Standard 18 **Stated:** First time	The registered provider should review the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: Examination of a sample of patients' records indicated that a care plan regarding the management of distressed reactions was in place. These medicines were rarely required to be administered; however, when administered, the reason for and the outcome of the administration were recorded. Staff also	

	provided details of other interventions used before medicines were administered.	
Area for improvement 3 **Ref**: Standard 29 **Stated:** First time	The registered provider should closely monitor the standard of record keeping in relation to personal medication records.	**Met**
	Action taken as confirmed during the inspection: An improvement in the standard of maintenance of personal medication records was evidenced at the inspection. Staff confirmed that these records were checked for accuracy at regular intervals as part of the audit process.	

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, supervision and annual appraisal. Competency assessments were completed annually. A programme of training was in place. In the last year, training in the management of medicines, syringe drivers, swallowing difficulty and dementia had been provided.

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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and to manage changes to prescribed medicines.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

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.

Discontinued or expired medicines were disposed of appropriately and two staff were involved in each disposal. With regard to controlled drugs, there were some occasions where the records did not indicate if they had been denatured and rendered irretrievable prior to disposal. This should be clearly stated and staff confirmed that this was the expected practice. The registered manager confirmed by email on 28 September 2017 that this had been addressed with staff.

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 of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessment, the management of medicines on admission/discharge, 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.

With the exception of a few medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. The administrations of those medicines which should be closely monitored were highlighted to staff and management. The registered manager gave an assurance that these would be included in the audit process.

On occasion some medicines were required to be crushed prior to administration or administered in disguised form. This was recorded in the patient's care plan. Consent had been obtained from the prescriber.

There were satisfactory arrangements in place to alert staff of when time critical medicines must be administered, such as early morning medicines and also medicines which were prescribed at weekly or twice weekly intervals. In relation to injectable medicines, staff had usually recorded the date the next dose was due; however, for one three monthly injection this date was not known. This was followed up with the prescriber during the inspection. The deputy manager confirmed that a specific chart for injections would be implemented with immediate effect.

When antibiotics were prescribed, a care plan was maintained. This is good practice.

The management of distressed reactions, swallowing difficulty and pain was reviewed. Of the sample of records examined, the relevant information was recorded in the patient's medicine records and care files. From discussion with staff it was evident that they were knowledgeable regarding patients' individual needs, their swallowing ability, how they would express pain and that any distressed reactions may be due to pain.

There were systems in place to facilitate patients who wish to self-administer their medicines. This was detailed in a signed protocol and care plan.

The management of medicines administered via an enteral feeding tube was reviewed. The patient's feeding regime and care plan were in place. The enteral feed was recorded on the personal medication record and the fluid intake was recorded. Staff were reminded that the total 24 hour fluid intake should also be recorded. It was agreed that this would be implemented.

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. They confirmed that most patients were generally compliant with their medicine regimes.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the maintenance of separate administration records for transdermal patches, high risk medicines and antibiotics; protocols for 'when required' medicines; and double signatures for the writing and updating of personal medication records and medication administration records.

Following discussion with the registered manager and staff, and a review of care files, it was evident that, when applicable, other healthcare professionals were contacted in response to the patients' healthcare needs.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the administration of medicines, the standard of record keeping and care planning. Staff were knowledgeable regarding the patients' medicines.

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 not observed at the inspection. Following discussion with staff, they confirmed that patients were given plenty of time to swallow their medicines. They provided examples of when medicines were administered at a later or earlier time to facilitate the patients' preferences/needs; and confirmed that they were aware of and adhered to the prescribed time intervals between 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. It was clear from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes.

The patients we met with spoke positively about their care and the management of their medicines. They were complimentary regarding staff and management. Comments included:

"They are very good to you."
"If I need anything, they get me it."
"They do look after you."
"I like it here."

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.

We met with staff throughout the inspection. Comments included:

"We have a good team."
"I enjoy my job."
"There is support from everyone."
"We get lots of training."

Of the questionnaires which were left in the home to facilitate feedback from patients, staff and relatives, two were returned from patients and one from staff. The responses indicated that they were very satisfied/satisfied with all aspects of the care in relation to the management of medicines.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the staff listening to and taking account of the views of patients.

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 in place. These were not examined in detail. Staff advised that they were familiar with them and were kept up to date of any changes.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents and advised of how incidents were shared with them to inform learning and change of practice, if necessary. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

The auditing arrangement for medicines was reviewed. Audits were completed by the registered nurses and management. The audits included records of running stock balances for several medicines which were not supplied in the 28 day blister packs. This is good practice. A review of the audit records indicated that largely satisfactory outcomes had been achieved. Staff advised of the procedures in place to manage any areas identified for improvement and provided details of where practice had changed.

Following discussion with the registered manager and 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. They advised that management were open and approachable and willing to listen. They also stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

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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