Unannounced Medicines Management Inspection Report
14 November 2016

Glenmachan Tower House

Type of Service: Nursing Home
Address: 13 Glenmachan Road, Belfast, BT4 2NN
Tel no: 028 9076 3441
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Glenmachan Tower House took place on 14 November 2016 from 09:30 to 13:15.

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 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.

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 Jane Murphy, 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 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 28 June 2016.

2.0 Service details

Registered organisation/registered person: Church of God - Glenmachan / Dr Albert Alan Stephens	**Registered manager:** Mrs Helen Jane Murphy
Person in charge of the home at the time of inspection: Mrs Helen Jane Murphy	**Date manager registered:** 01 April 2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 39

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, two registered nurses and one patient's representative.

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. One relative availed of this opportunity during the inspection.

Twenty-five questionnaires were issued to patients, patients' representatives and staff with a request that they were returned within one week from the date of this inspection.

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 28 June 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 07 January 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time	The necessary arrangements must be made to ensure that the act of administering medication in disguised form to a patient is undertaken in accordance with current best practice as defined by professional bodies and national standard setting organisations and that the assessment process and outcomes are documented in the patient's notes. **This requirement is carried forward from the previous inspection.**	**Met**
	Action taken as confirmed during the inspection: Although the registered manager and nursing sister advised that no patients were currently required to have medication administered covertly, there was a written policy in place should this scenario arise in the future.	

Requirement 2 **Ref:** Regulation 20(1) **Stated:** First time	The registered provider must maintain a record of staff competency and capability assessments with respect to the management of medicines.	**Met**
	Action taken as confirmed during the inspection: The registered manager provided a record of staff medicines management competency and capability assessments.	
Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered provider must ensure that medication audit discrepancies of greater than +/-5% for solid-dose formulations and +/-10% for liquid formulations are reported to RQIA as notifiable incidents.	**Met**
	Action taken as confirmed during the inspection: Several medication incidents had been reported to RQIA since the previous medicines management inspection.	
Requirement 4 **Ref:** Regulation 13(4) **Stated:** First time	The registered provider must introduce more robust arrangements for both auditing the administrations of medicines not contained in the monitored dosage system trays and ensuring that audit discrepancies are promptly addressed.	**Met**
	Action taken as confirmed during the inspection: The registered manager provided recorded evidence that monthly audits were performed on a random selection of medicines not contained in the monitored dosage system trays. There was also evidence of discrepancies having been addressed.	
Requirement 5 **Ref:** Regulation 13(4) **Stated:** First time	The registered provider must ensure that the patient's medication allergy status is routinely recorded on their personal medication record sheet.	**Met**
	Action taken as confirmed during the inspection: The patient's medication allergy status was observed to be recorded on their personal medication record sheet.	

Requirement 6 **Ref:** Regulation 13(4) **Stated:** First time	The registered provider must ensure that the temperature of the medicines refrigerator is appropriately managed in order to ensure medicines needing cold storage are kept under appropriate conditions.	**Met**
	Action taken as confirmed during the inspection: The temperature range of the medicines refrigerator was monitored daily and indicated that the temperature had been maintained within the recommended limits.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	A daily running balance of warfarin tablets should be maintained.	**Met**
	Action taken as confirmed during the inspection: Daily running balances of warfarin tablets had been maintained.	
Recommendation 2 **Ref**: Standard 37 **Stated:** First time	The registered provider should update the Standard Operating Procedures for the management of controlled drugs with respect to disposal and incident reporting in order to reflect actual practice.	**Met**
	Action taken as confirmed during the inspection: The Standard Operating Procedures for the management of controlled drugs had been updated with respect to disposal and incident reporting in order to reflect actual practice.	
Recommendation 3 **Ref**: Standard 37 **Stated:** First time	The registered provider should expand the current audit activity to include other areas of medicines management.	**Met**
	Action taken as confirmed during the inspection: The registered provider had expanded the medicines management audit activity.	

Recommendation 4 **Ref**: Standard 38 **Stated:** First time	The registered provider should develop a policy which clearly defines what time frame each meal time refers to with respect to the administration of medicines.	**Met**
	Action taken as confirmed during the inspection: A policy had been developed which clearly defined what time frame each meal time refers to with respect to the administration of medicines.	

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. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually.

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 medicine 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.

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

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 and 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 mostly recorded. A care plan was not maintained for one patient; the registered manager gave an assurance that this matter would be rectified without delay.

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 the pain was well controlled and the patient was comfortable. Staff advised that most of the patients could verbalise any 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. Care plans and speech and language assessment reports were in place. The nursing staff had recorded administrations, however, the care staff did not record this information; the registered manager gave an assurance that this matter would be rectified without delay.

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.

Practices for the management of medicines were audited throughout the month by the management.

Following discussion with the registered manager and staff, it was evident that there were good working relationships with other healthcare workers, including the community pharmacist and prescribers.

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 spoken to advised that they were very satisfied with the care they received. One relative stated that the care in the home was “fabulous.”

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.

As part of the inspection process, we issued questionnaires to staff, patients and patients’ representatives. Five patients, three staff and one patient’s representative completed and returned questionnaires within the specified timeframe. Comments received were very positive; the responses were recorded as ‘satisfied’ or ‘very satisfied’ with the management of medicines 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. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them.

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

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.

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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