Unannounced Medicines Management Inspection Report
11 October 2016

Lansdowne

Type of Service: Nursing Home
Address: 41- 43 Somerton Road, Belfast, BT15 3LG
Tel no: 028 9037 0911
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Lansdowne took place on 11 October 2016 from 10.20 to 16.30.

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 most areas of the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff responsible for medicines management had been trained and deemed competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. However, one area for improvement in relation to stock control was identified. One recommendation was made.

Is care effective?

The management of medicines supported the delivery of effective care. There were largely satisfactory systems in place to ensure patients were receiving their medicines as prescribed. Some discrepancies in the medicine audit trails were identified and highlighted to staff and management. Care plans relating to specific areas of medicines management were in place e.g. pain, warfarin, diabetes, enteral feeding, dysphagia. In relation to the management of distressed reactions, one area for improvement was identified and a recommendation was made.

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 and relatives spoken to were complimentary about their care/relative's care in the home and the management of their medicines. No requirements or recommendations were made.

Is the service well led?

The service was found to be generally 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. Whilst there was evidence of a variety of auditing systems for medicines management, some discrepancies in the audit trails were identified and a recommendation regarding the auditing process was 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.

1.1 Inspection outcome

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with the Registered Manager, Mrs Karen Agnew, 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 22 August 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/ Dr Maureen Claire Royston	**Registered manager:** Mrs Karen Agnew
Person in charge of the home at the time of inspection: Mrs Karen Agnew	**Date manager registered:** 10 March 2016
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 86

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 member of care staff, three registered nurses, the registered manager and two relatives.

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 22 August 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was due for return on 11 October 2016. Once returned this QIP will be reviewed by the care inspector and will be validated at their next care inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection on 22 October 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 38 **Stated:** Second time	The registered person should review the process for the administration of external preparations to ensure records are fully and accurately completed on every occasion.	**Met**
	Action taken as confirmed during the inspection: Improvements were noted in the administration records for external preparations. These medicines were administered by registered nurses and care staff. These medicines were included in the auditing process.	
Recommendation 2 **Ref**: Standard 39 **Stated:** Second time	The registered person should ensure that all blood glucometer control solutions are viable for use.	**Met**
	Action taken as confirmed during the inspection: Satisfactory arrangements were in place to monitor blood control solutions. Those examined were marked with the date of opening, were viable for use and were checked as part of the audit process.	

Recommendation 3 **Ref**: Standard 31 **Stated:** First time	It is recommended that all registered nurses are made aware of the changes to the controlled drug schedules and which controlled drugs require denaturing prior to disposal.	**Met**
	Action taken as confirmed during the inspection: Staff had been provided with training on controlled drug schedules and there was evidence that controlled drugs in Schedules 2 to 4 (Part 1) had been denatured prior to disposal.	

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. Refresher training in medicines management, enteral feeding and syringe drivers was provided in the last year. Training regarding the management of influenza, vaccines and anaphylaxis is planned for later in October 2016.

The system to manage the ordering of prescribed medicines was reviewed. For the majority of medicines this was satisfactory. However, it was noted that two medicines had been out of stock in the last medicine cycle and this had resulted in a number of missed doses; this had not been reported to the registered manager. For one patient some medicines had not been received on time for the new medicine cycle which commenced on 10 October 2016. Some doses had been missed and this was being followed up by management. A review of the ordering and stock control process for medicines was recommended, to ensure that all medicines are available for administration as prescribed and any potential shortfalls are readily identified and followed up.

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.

Discontinued or expired medicines were disposed of appropriately. 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. However, it was noted that one insulin pen device had recently passed the expiry date and was removed and replaced during the inspection. It was agreed that this would be raised with the registered nurses and would be checked each month.

Medicine refrigerators and oxygen equipment were checked at regular intervals. Staff were reminded that empty cylinders of oxygen should not be stored with full cylinders and that all cylinders should be chained to the wall.

Areas for improvement

The stock control of medicines should be reviewed to ensure that all medicines are available for administration. A recommendation was made.

Number of requirements	0	**Number of recommendations**	1

4.4 Is care effective?

The majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. Some discrepancies in the audit trails performed on medicines which had not been supplied in the 28 day blister packs were identified and highlighted. A recommendation regarding the audit process was made in section 4.6.

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. A care plan was maintained for all but one of the patients records examined. The registered nurse advised that this would be put in place by the end of the day. Following discussion with staff it was evident that they 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. Whilst a record of administration was recorded, the reason for and the outcome of administration were not routinely documented. A recommendation was made.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. A care plan was maintained. Staff advised that some of the patients could verbalise pain and that when a patient could not express pain, a pain assessment tool was used. Staff also advised that a pain assessment was completed as part of the admission process. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. The good practice of maintaining a separate pain evaluation chart which included the type of pain and the outcome of the administration of pain controlling medicines was acknowledged.

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.

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.

Satisfactory arrangements were in place for the management of medicines administered via an enteral feeding tube and the administration of medicines which were required to be crushed/or capsules opened prior to administration.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for insulin, warfarin, antibiotics and transdermal patches.

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 regarding medicines management.

Areas for improvement

The reason for and the outcome of the administration of medicines prescribed on a "when required" basis for the management of distressed reactions should be recorded on every occasion. A recommendation was made.

Number of requirements	0	**Number of recommendations**	1

4.5 Is care compassionate?

The administration of medicines to patients was not observed at the inspection. Following discussion with the registered manager and registered nurses it was ascertained that medicines were administered to patients in a caring manner and they were given time to take their medicines. Staff provided examples of where a patient would have their medicines later in the morning as they liked to stay in bed for a while. Staff confirmed that this did not impact on the minimum time intervals for medicines which were prescribed throughout the day.

The patient spoken to advised that they were satisfied with the manner in which their medicines were managed and administered. They advised that staff responded in a timely manner to any requests for medicines. They spoke positively about the staff.

The relatives we spoke with stated that they were content with the care of their relative and also spoke positively about the staff.

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. These were reviewed earlier this year. 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.

Practices for the management of medicines were audited throughout the month by the registered nurses, senior care staff and management. This included running stock balances for analgesics, laxative sachets, inhaled medicines and nutritional supplements. In addition, a quarterly audit was completed by the community pharmacist. Staff had recorded the date of opening on medicines and the stock balance of medicines which were carried forward to the next medicine cycle. This good practice readily facilitated the audit process. However, as there were areas identified for improvement in the domains of safe and effective care, the auditing process should be further developed. A recommendation was made.

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. The registered manager advised that staff would be reminded that she must be informed when any medicines were out of stock.

The 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 shift handover, supervision and/or team meetings.

Areas for improvement

The audit process should be further developed. A recommendation was made.

Number of requirements	0	**Number of recommendations**	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the Registered Manager, Mrs Karen Agnew, 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 the **web portal** 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 28 **Stated:** First time **To be completed by:** 10 November 2016	The registered provider should ensure there are robust arrangements in place for the ordering and supply of medicines.
	Response by registered provider detailing the actions taken: The management for the ordering and supply of medicines has been rationalised so it is under the supervision of the deputy manager for all three units. It is anticiapted that the oversight of one designated person will improve the current systems.
Recommendation 2 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 10 November 2016	The registered provider should ensure that where medicines are prescribed for use on a “when required” basis for the management of distressed reactions, the reason for and the outcome of the administration are recorded on every occasion.
	Response by registered provider detailing the actions taken: Discussed with trained staff team and will be audited by home manager for complaince
Recommendation 5 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 10 November 2016	The registered provider should ensure that the audit process is further developed.
	Response by registered provider detailing the actions taken: Random checks of boxed mediactions will be undertaken weekly to validate the results of the current daily boxed medication counts

Please ensure this document is completed in full and returned via the web portal

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