Unannounced Medicines Management Inspection Report
1 June 2017

Balmoral View Care Centre

Type of Service: Nursing Home
Address: 5 The Manor, Blacks Road, Dunmurry, BT10 0NB
Tel No: 028 9062 9331
Inspector: Rachel Lloyd

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 39 beds that provides care for patients and residents living with old age and/or physical disability, dementia or who are terminally ill. It was formerly known as Manor Lodge.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** Mr Rosendo Soriano
Person in charge at the time of inspection: Mr Adrian Turturica (Deputy Manager on secondment from Beechill – a local nursing home run by the same provider)	**Date manager registered:** 5 May 2017
Categories of care: Nursing care (NH): I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) – Physical disability other than sensory impairment – over 65 years TI – Terminally ill DE – Dementia Residential care (RC): I – Old age not falling within any other category	**Number of registered places:** 39 comprising: 37 nursing and 2 residential. A maximum of 15 patients in category NH-DE to be accommodated in the dementia unit.

4.0 Inspection summary

An unannounced inspection took place on 1 June 2017 from 10.40 to 16.00.

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.

The term ‘patients’ is used to describe those living in Balmoral View Care Centre, which provides both nursing and residential care.

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 staff training and the sharing of information with staff regarding the management of medicines, the maintenance of personal medication records and medication administration records, the management of controlled drugs and the storage of medicines.

Areas requiring improvement were identified in relation to the management of medicines on admission and the records of medicines received. The former was stated for the second time.

Patients’ comments indicated that they were satisfied with the management of medicines 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	*1	1

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mr Adrian Turturica, Deputy Manager from Beechill, and Ms Codrina Aioanei, Deputy 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.

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 23 February 2017. Enforcement action did not result from the findings of this inspection.

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

During the inspection we met with three patients, one relative, one registered nurse, the deputy manager and the deputy manager from Beechill.

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

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

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

Areas for improvements 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 23 February 2017

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 the next care inspection.

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

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered provider must ensure that the procedures in place to ensure the safe management of medicines during a patient's admission to the home are reviewed.	**Partially Met**
	Action taken as confirmed during the inspection: Procedures were largely satisfactory in the majority of examples examined. For one respite patient, medicines received on admission had not been receipted. Medicines had been received in a dossette box which was not tamper proof. Although labelled, individual medicines could not be identified. This was not in accordance with the home's own policy and procedures. One prescribed medicine was not in stock/use. Staff stated that this medicine had not been used by the patient at home and that this had been discussed with the patient's relatives. Staff were advised to record these details in the patient's care plan. **This area for improvement was stated for the second time.**	

Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered provider must ensure that the discrepancies in the dose of warfarin administered are investigated and that systems are reviewed to ensure that the management of warfarin is robust.	**Met**
	Action taken as confirmed during the inspection: Staff confirmed that these discrepancies had been investigated and that systems in place to manage warfarin had been revised following the last inspection. A recent record of warfarin administration was examined. The date and day of the week were recorded. Warfarin was not prescribed for any patient at the time of this inspection. Due to the evidence observed and the assurances received, this area for improvement was assessed as met.	
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time	The registered provider must ensure that the storage of controlled drugs in the dementia unit is reviewed to ensure that those medicines requiring safe custody are stored appropriately.	**Met**
	Action taken as confirmed during the inspection: All controlled drugs requiring safe custody were stored appropriately.	
Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time	The registered provider must ensure that personal medication records are maintained accurately at all times.	**Met**
	Action taken as confirmed during the inspection: The personal medication records examined had been maintained in a satisfactory manner.	
Area for improvement 5 **Ref:** Regulation 13 (4) **Stated:** First time	The registered provider must ensure that medicine administration records are maintained accurately at all times.	**Met**
	Action taken as confirmed during the inspection: The medication administration records examined had been maintained in a satisfactory manner.	

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 ensure that the procedures in place to manage changes to prescribed medicines are reviewed.	**Met**
	Action taken as confirmed during the inspection: The changes to prescribed medicines examined had been managed appropriately. Two registered nurses had checked and signed any handwritten additions to records.	
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: The date of opening was recorded on the majority of medicines examined and on all of those medicines examined with a limited shelf life, once opened.	
Area for improvement 3 **Ref:** Standard 18 **Stated:** First time	The registered provider should ensure that the reason for and the outcome of the administration of medicines prescribed for use on a "when required" for distressed reactions is recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: The reason for and the outcome of administration were recorded on most occasions examined. A distressed reaction monitoring record sheet was in place to prompt staff to record these details. Staff were reminded to record these details on every occasion.	

Area for improvement 4 **Ref:** Standard 28 **Stated:** First time	The registered provider should ensure that the auditing process is reviewed, to ensure that it covers all aspects of medicines management and that there is a robust system in place to follow up areas identified for improvement.	**Met**
	Action taken as confirmed during the inspection: Improvements in audit procedures were observed. Management audits had been completed and were available for examination. Daily and weekly audits were completed by staff and audits were also completed by the community pharmacist. Staff confirmed that outcomes were discussed during staff meetings and supervision.	

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

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available. Staff advised of the procedures to identify and report any potential shortfalls in medicines. Some examples of disposal of currently prescribed medicines as 'overstock' were identified. These were discussed with staff who advised that procedures had been recently reviewed and that stock is only ordered as necessary. This had been discussed with the prescribers and pharmacist to reduce possible wastage. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There procedures in place to ensure the safe management of medicines during a patient's admission should be reviewed (see section 6.2). An area for improvement identified at the last medicines management inspection was stated for the second time.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Antibiotics and newly prescribed medicines were received into the home without delay. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses.

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.

Appropriate arrangements were in place for administering medicines in disguised form.

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 organised. There were satisfactory 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 in relation to staff training and competency assessment, medicine storage and the management of controlled drugs.

Areas for improvement

One area for improvement was identified for the second time, in relation to the management of medicines during a patient's admission to the home.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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, 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 records. Care plans were in place. 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 outcome of the administration of these medicines was recorded on most occasions.

The management of pain was reviewed for two patients. Care plans were in place. The 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 patients were comfortable. Staff advised that not all patients could verbalise any pain, and a pain assessment tool was used as needed.

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 or referrals 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.

Medicine records were mostly well maintained and facilitated the audit process. Staff were advised to carry forward the balance of medicines, not included in the monitored dosage system, at the start of each medicine cycle to facilitate the audit process. One area for improvement was identified in relation to the receipt of incoming medicines. Whilst regular medicines had been accurately recorded on receipt, some acute medicines and medicines received at admission had not been recorded.

Practices for the management of medicines were audited throughout the month by the staff and management. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered nurses, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas of good practice

There were examples of good practice found in relation to the maintenance of care planning and the administration of medicines.

Areas for improvement

Procedures should be reviewed to ensure that all incoming medicines received are accurately recorded.

	Regulations	Standards
Total number of areas for improvement	0	1

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 observed briefly and was completed in a caring manner. Patients were given time to take their medicines and medicines were administered as discreetly as possible.

Staff were noted to be friendly and courteous; they treated the patients with dignity. Patients who could not verbalise their feelings in respect of their care were observed to be comfortable in their surroundings and in their interactions with staff.

The patients spoken to had no concerns regarding the management of their medicines and advised that staff responded in a timely manner to any requests for pain relief. The relative spoken to had no concerns regarding the management of their relative's medicines and advised that staff communicated with them effectively. They were mostly complimentary about the staff and the care provided in the home.

Fifteen questionnaires were left in the home to facilitate feedback from patients, staff and relatives. No questionnaires were returned within the requested timescale.

Areas of good practice

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

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. 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 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. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

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 staff, it was evident that they 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 with the staff concerned. One registered nurse advised that due to the layout of the second floor it is sometimes difficult for one nurse to monitor all patents effectively. The management on duty was advised and agreed to discuss this with the registered manager.

One of the areas for improvement identified at the last medicines management inspection had not been satisfactorily addressed. 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 of good practice

There were examples of good practice found in relation to the management of medicine incidents, audit procedures and the sharing of information with staff regarding the management of medicines.

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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Adrian Turturica, Deputy Manager from Beechill and Ms Codrina Aioanei, Deputy Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** Second time **To be completed by:** 1 July 2017	The registered person shall ensure that the procedures in place to ensure the safe management of medicines during a patient's admission to the home are reviewed. **Ref: 6.2 & 6.4**
	Response by registered person detailing the actions taken: All nursing staff are aware and adhere to FSHC company policy and procedures in the safe management of medicines during a patient's admission to the home.
Action required to ensure compliance with The Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 1 July 2017	The registered person shall ensure that procedures are reviewed to ensure that all incoming medicines received are accurately recorded. **Ref: 6.5**
	Response by registered person detailing the actions taken: All nursing staff are aware that all incoming medicines received are recorded accurately in the medication receipt book.

***Please ensure this document is completed in full and returned via the Web Portal ***

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