Unannounced Medicines Management Inspection Report
18 July 2017

Mount Lens

Type of Service: Nursing Home
Address: 166 Kings Road, Belfast, BT5 7EL
Tel no: 028 9048 5483
Inspector: Helen Daly

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 31 beds that provides care for patients living with dementia. Care is also provided for four identified frail elderly patients with no further admissions to take place in this category.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual(s):** Dr Maureen Claire Royston	**Registered Manager:** Mrs Joly Shibu
Person in charge at the time of inspection: Mrs Joly Shibu	**Date manager registered:** 29 June 2016
Categories of care: Nursing Homes NH: DE - dementia I – old age not falling within any other category	**Number of registered places:** 31 Category NH-I for 4 identified persons only with no further admissions to take place in this category.

4.0 Summary

An unannounced inspection took place on 18 July 2017 from 10.20 to 14.45.

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 medicines administration, medicine records, storage and the management of controlled drugs.

One area for improvement was identified in relation to the management of medicines and nutrition via the enteral route.

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	1

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Joly Shibu, 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.

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 10 May 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 records:

- 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 two care assistants, the registered nurse and the registered manager.

A total of 15 questionnaires were provided for distribution to patients, their representatives 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 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 10 May 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last medicines management inspection dated 9 May 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 18 **Stated:** First time	The reason for each administration and subsequent outcome should be recorded, when a patient is prescribed a medicine for administration on a "when required" basis for the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: The reason for the administration and subsequent outcome was being recorded for medicines prescribed to be administered on a "when required" basis for the management of distressed reactions.	

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. Registered nurses had attended training provided by the community pharmacist within the last year. Training on the management of medicines was also completed via e-learning. Competency assessments were completed annually. The registered manager confirmed that all registered nurses had been trained and deemed competent to manage medicines and nutrition via the enteral route. An induction process was in place for agency nurses; confirmation of their training and competency was provided by the nursing agency. Care assistants had received training on the administration of thickening agents and application of emollient preparations in February 2017.

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 was evidence that newly prescribed medicines and antibiotics were received into the home without delay.

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. However, for one recent admission, records of medicines received had not been accurately maintained and the month of administration had not been recorded on hand-written medication administration records. This meant that there was not a clear audit trail to provide evidence that the medicines had been administered as prescribed. These findings were investigated by the registered manager who emailed RQIA the day after the inspection to confirm that supervisions would be carried out with all registered nurses and that the management of medicines on admission would be closely monitored as part of the home's ongoing audit activity. Due to these assurances an area for improvement was not identified.

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.

The management of medicines and nutrition via the enteral route was reviewed and found to be mostly satisfactory. The following areas for improvement were identified:

- the times of administration of medicines and the enteral feed should be clearly detailed on the personal medication record
- there should be a detailed regimen for the administration of each medicine
- the fluid intake chart should be totalled each day to ensure that the recommended intake is achieved

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. It was noted that refrigerator temperatures were sometimes above $8^{o}C$; the registered manager had already been made aware and corrective action was being taken.

Following up on a recent call to our duty desk, we triggered a pressure mat outside a patient's room; this was responded to by staff in a timely manner.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and controlled drugs.

Areas for improvement

The registered person shall review and revise the management of medicines and nutrition via the enteral route to ensure that:

- the times of administration of medicines and the enteral feed are clearly detailed on the personal medication record
- there is a detailed regimen for the administration of each medicine
- the fluid intake chart is totalled each day to ensure that the recommended intake is achieved

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

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

The majority of medicines examined had been administered in accordance with the prescriber's instructions. A small number of minor discrepancies were discussed with the registered manager and registered nurse for ongoing monitoring.

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.

The management of distressed reactions was reviewed. 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 or infection. Care plans were in place. When a medicine was prescribed for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. Protocols for administration and sheets to record the reason for and outcome of administration were in place. A review of these sheets indicated that entries correlated with the actual administration of the medicine.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans and pain management protocols were in place. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff advised that some patients could not verbalise their pain, a pain 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 were in place. Administration was being recorded.

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 protocols for the administration of pain relief and anxiolytics and the additional recording sheets for transdermal patches.

Practices for the management of medicines were audited throughout the month by staff and management. This included running stock balances for several medicines which were not supplied in the blister pack system. In addition a weekly audit was completed by the nursing sisters; these audits were reviewed by the registered manager. A quarterly audit was completed by a representative from the community pharmacy.

Following discussion with the registered manager and staff, 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 in relation to the standard of record keeping, care planning and the administration of 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 completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Buzzers and alarms were being responded to without delay.

Of the questionnaires that were issued, two were returned from relatives and two were returned 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

Staff were observed to listen to patients and respond promptly to their requests.

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; a copy was available in the treatment rooms. 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. Medicine related incidents reported since the last medicines management inspection were discussed; there was evidence of the action taken and learning implemented following incidents. Staff were aware that incidents involving medicines may need to be reported to the 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 registered manager, registered nurse and care 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 any resultant action was communicated with all staff.

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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Joly Shibu, Registered 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 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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 18 August 2017	The registered person shall review and revise the management of medicines and nutrition via the enteral route as detailed in the report.
	Response by registered person detailing the actions taken: 1.The times of administrations for both medicines and enteral feed are detailed on Kardex and Personal Medication Record. 2. A detailed regimen for administration of each medicine is available for nurses to ensure that the instructions are adhered to as per policy. 3.The fluids administered during enteral feeding are recorded on the Gastrostomy tube feed chart each day to ensure that the daily target is achieved.

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

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