

Unannounced Medicines Management Inspection Report 3 July 2017



Parkdean

Type of Service: Nursing Home
Address: 44 Fortwilliam Park, Belfast, BT15 4AN
Tel no: 028 9037 0406
Inspector: Judith Taylor

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 64 beds that provides care for patients living with a variety of care needs.

3.0 Service details

Organisation/Registered Provider: Parkdean Responsible Individual: Mrs Emer Bevan	Registered manager: See box below
Person in charge of the home at the time of inspection: Mrs Lilibeth Moffett	Date manager registered: Mrs Lilibeth Moffett Acting- No Application Required
Categories of care: <u>Nursing Home (NH)</u> 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	Number of registered places: 64

4.0 Inspection summary

An unannounced inspection took place on 3 July 2017 from 09.50 to 14.40.

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 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 administration of medicines, the governance arrangements for medicines including controlled drugs, the standard of record keeping and storage of medicines.

No areas for improvement were identified at this inspection.

The patients we spoke with were complimentary about 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 Mrs Lilibeth Moffett, Acting Manager and the deputy 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 premises inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 7 March 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 incidents: it was ascertained that no medicine related incidents had been 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 the inspector met with three patients, two registered nurses, the deputy manager and the acting 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 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 7 March 2017

The most recent inspection of the home was an announced premises inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at the next premises inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 9 February 2017

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 29 Stated: First time	The registered provider should ensure that, when a patient is prescribed a thickening agent the fluid consistency is recorded on all relevant records.	Met
	Action taken as confirmed during the inspection: A number of patients were prescribed thickening agents. Five patients' records were examined. The fluid consistency was recorded on the patients' personal medication records, administration records and care plans. This information was also included in the list of patient's names and their bedroom number. This list was used to assist staff with patients' daily care needs.	

Area for improvement 1 Ref: Standard 29 Stated: First time	The registered provider should ensure that the route of application of eye-treatment medicines is recorded on the personal medication record sheets.	Met
	Action taken as confirmed during the inspection: Eight eye preparations were reviewed at the inspection. The personal medication record and administration records clearly stated the route of administration. In addition, a reminder alert was located in the medicine ring binders to assist with the medicine round. All eye preparations were marked with the date of opening to facilitate replacement once the in use expiry date had been reached.	

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. Samples of training records and staff competency assessments were provided. There was evidence of the induction process completed by registered nurses; and for care staff who had been delegated medicine related tasks, i.e. oral nutritional supplements, thickening agents and external preparations. The impact of training was monitored through team meetings, supervision and annual appraisal. Refresher training in medicines management was provided in the last year. This was at six monthly intervals. Training in the management of subcutaneous fluids and syringe drivers had also been provided.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. One registered nurse has been appointed as the designated trainer for safeguarding.

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 discharge from the home; and for the management of medicine changes. A specific record book was in use to record any medicine changes and also used for staff reference.

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 anticoagulants. It was suggested that a daily stock balance should be maintained for anticoagulant injections.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. A separate disposal book was used solely for controlled drugs. This is good practice.

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 on a daily basis.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 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. These satisfactory outcomes were acknowledged.

There was evidence that time critical medicines had been administered at the correct time. Alert stickers were affixed to patient's records to remind staff that medicines prescribed for Parkinsons' were given on time. This is good practice.

There were arrangements in place to alert staff when doses of weekly or three monthly medicines were due.

The management of distressed reactions was examined. The necessary information was recorded on the medicine records and care plans. These medicines were rarely required.

Several patients were prescribed medicines for the management of pain. This was detailed in the patient's care plan and pain assessment tools were used as needed. Staff were aware of how patients would express pain. The sample of records examined indicated that pain controlling medicines had been administered as prescribed. The patients we spoke with also confirmed that the staff would administer their pain relief on a regular basis or if they requested it.

The management of enteral feeding was reviewed. The relevant records were being maintained. The feeding regime was in place and was also detailed in the patient's care plan.

Satisfactory arrangements were in place for the management of thickening agents. Care plans and speech and language assessment reports were in place. See also Section 6.2.

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 patients were generally compliant with their medicine regimes. In relation to one patient, they described the action taken following the patients ongoing refusal of medicines.

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 some injectable medicines, transdermal patches, antibiotics and warfarin, warnings for patients with similar names and double signatures for the writing and updating of personal medication records and medication administration records.

Following discussion with the manager and staff and a review of care plans and medicine records, it was evident that when applicable, other healthcare professionals were contacted in response to 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 plans. 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 completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible.

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' needs, their 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:

"the care here is good"

"I am happy enough"

"I had a lovely breakfast"

"the staff here are brilliant"

"everything is ok here"

At the time of issuing this report, one questionnaire had been returned. This was from a patient's representative. The responses indicated that they were satisfied with all aspects of the care in relation to the management of medicines.

Areas of good practice

There was evidence that staff listened to patients and relatives and took account of their views.

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 robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report 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.

The procedures to audit medicines management were reviewed. A variety of medicine audits were undertaken. These were completed on a daily and monthly basis by registered nurses and management. Running stock balances were maintained for several medicines which were not supplied in the 28 day blister packs, including oral nutritional supplements. This is best practice. In addition to this, we were advised that three patients' medicines were reviewed each day. An audit was also completed by the community pharmacist on a periodic basis. A review of the audit records indicated that satisfactory outcomes had been achieved. Management advised of the procedures in place to manage any identified areas for improvement.

Following discussion with management and registered nurses, 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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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