Unannounced Medicines Management Inspection Report
9 February 2017

Parkdean

Type of Service: Nursing Home
Address: 44 Fortwilliam Park, Belfast, BT15 4AN
Tel no: 02890370406
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Parkdean took place on 9 February 2017 from 09:45 to 14:15.

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 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 generally supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Two areas of improvement were identified in relation to record keeping and two recommendations were 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. 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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Lilibeth Moffett, 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.

1.2 Actions/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Parkdean Ms Emer Bevan	**Registered manager:** See box below
Person in charge of the home at the time of inspection: Registered Nurse Judy Pena	**Date manager registered:** Ms Lilibeth Moffett Acting- No Application Required
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 64

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 five patients, the manager, four registered nurses and two care staff.

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.

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.
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
- care plans
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 17 November 2016

The most recent inspection of the home was an unannounced care inspection. No requirements or recommendations were made.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 16 July 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person must ensure that all controlled drugs in Schedules 2, 3 and 4 (Part 1) are denatured in the home prior to disposal.	**Met**
	Action taken as confirmed during the inspection: Following discussion with the manager and nursing staff and review of the disposal of medicines record, it was evident that controlled drugs in Schedules 2, 3 and 4 (Part 1) were denatured in the home 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 was provided to the nursing staff in the last year.

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.

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. 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. A care plan was maintained. These medicines were seldom used.

The sample of 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 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. Where a patient was able to verbalise pain, they completed a self-assessment form. Staff also advised that a pain assessment is 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 medicine administration record. However, these records did not include details of the fluid consistency. Also, for one of the two patients whose records were reviewed, the care plan did not specify the fluid consistency. The fluid consistency should be recorded in the care plan, personal medication record and medicine administration record; a recommendation was made. Administrations were recorded 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.

Medicine records were well generally well maintained and facilitated the audit process. The route of application of eye-treatment medicines was generally not recorded on the personal medication record sheets; a recommendation was made. Where a patient had more than one personal medication record sheet in use, this was not recorded on each sheet; the manager gave an assurance that this matter would be rectified without delay. The use of separate administration charts for antibiotic courses, injections, insulin, transdermal patches and warfarin was acknowledged.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for most boxed medicines, nutritional supplements and inhaled medicines.

Following discussion with the manager and staff, it was evident that, when applicable, other healthcare professionals are contacted in response to patients' needs.

Areas for improvement

When a patient is prescribed a thickening agent, the fluid consistency should be recorded on all relevant records.

The route of application of eye-treatment medicines should be recorded on the personal medication record sheets.

Number of requirements	0	**Number of recommendations**	2

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 advised that they were very satisfied with the care experienced.

As part of the inspection process, we issued questionnaires to patients, patients' representatives and staff. Seven patients 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.

One member of staff also completed a questionnaire. The responses were positive and raised no concerns about the management of medicines in the home.

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. From 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.

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 manager, registered nurses 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.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Lilibeth Moffett, Manager, 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 pharmacists@rqia.org.uk / 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 29 **Stated:** First time **To be completed by:** 11 March 2017	The registered provider should ensure that, when a patient is prescribed a thickening agent the fluid consistency is recorded on all relevant records.
	Response by registered provider detailing the actions taken: Fluid consistency for residents who have difficulty swallowing is recorded on all relevant records. Following an assessment or review of the resident, instructions from SALT services is in the careplan. Guidelines for thickening liquids has now been put in place as reflective of SALT recommendation, and the right consistency has now been written on the Kardex and Medication Administration Record Sheets. Reference about Dysphagia swallowing has been made available for all care staff to easily access for additional information.
Recommendation 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 11 March 2017	The registered provider should ensure that the route of application of eye-treatment medicines is recorded on the personal medication record sheets.
	Response by registered provider detailing the actions taken: The administration of topical eye medications must be given the same priority and attention to safety as drugs administered by the systematic route. To facilitate good record keeping and safe administration of topical eye medication. Route of application for eye treatment medicines as prescribed has now been clearly recorded on Kardex, Medication Administration Record Sheets and also reflected on care plans. Alert cards are now in place for residents receiving eye treatment. Alert cards were created which contains vital information to prompt trained staff during medication rounds that includes the resident's name, medication prescribed and specific route of administration.

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address

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