Unannounced Medicines Management Inspection Report
14 July 2016

Scrabo Isles

Type of Service: Nursing Home
Address: 61 Manse Road, Newtownards, BT23 4TP
Tel No: 028 9181 2231
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Scrabo Isles took place on 14 July 2016 from 09:45 to 14:30.

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 the management of medicines supported the delivery of safe care which promoted positive outcomes for patients. Staff were trained and competent and there were robust systems for the management of high risk medicines. However improvements in the management of medicines for home visits and the management of updates on the personal medication records are necessary. Two recommendations have been made.

Is care effective?

There was evidence that most areas of the management of medicines supported the delivery of effective care for patients. There were systems in place to ensure that patients were administered their medicines as prescribed. Robust arrangements were in place for the management of pain. One medication related incident was highlighted and a requirement has therefore been made. One recommendation in relation to the records in place for distressed reactions has been made.

Is care compassionate?

There was evidence that the management of medicines supported the delivery of compassionate care. Staff interactions with patients were observed to be compassionate, caring and timely. No requirements or recommendations have been made.

Is the service well led?

There was evidence that the service was well led with respect to the management of medicines. Written medicine policies and procedures were in place. There were systems to manage and share the learning from medicine related incidents and areas identified within the audit process. No requirements or recommendations have been 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.

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	1	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Bernie Camilo, Nurse in Charge, 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 inspection on 25 April 2016.

2.0 Service details

Registered organisation/registered provider: Tona Enterprises Ltd Mr Robert Maxwell Duncan	**Registered manager:** Ms Annalyn Depayso
Person in charge of the home at the time of inspection: Ms Bernie Camilo (Nurse in Charge)	**Date manager registered:** 27 March 2009
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 35

3.0 Methods/processes

Prior to inspection the following records were analysed:

- inspection reports and returned QIPs
- recent correspondence with the home
- the record of notifiable incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

We met with one patient, two care assistants, one registered nurse and the nurse in charge.

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 25 April 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the care inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 12 May 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time	It is a requirement that the registered person must closely monitor the administration of Ebixa liquid 5mg/actuation. Any further discrepancies must be investigated and reported to the appropriate authorities, including RQIA.	**Met**
	Action taken as confirmed during the inspection: The date of opening and due date for completion are now recorded on the containers to facilitate the audit process. Two supplies were audited at the inspection and satisfactory outcomes were observed.	
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time	It is a requirement that the registered person must ensure that the refrigerator thermometer is reset each day after the current, maximum and minimum temperatures have been recorded.	**Met**
	Action taken as confirmed during the inspection: Satisfactory recordings for the refrigerator temperature were observed indicating that the thermometer was being reset each day.	

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 had been completed in June 2016. Refresher training was provided via e-learning. A system to alert staff to when training is to be updated was in place.

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.

Mostly satisfactory arrangements were in place to manage changes to prescribed medicines. Handwritten entries on medication administration records were updated by two registered nurses, however, updates on the personal medication records were not signed and verified. A recommendation was made.

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, robust systems were not in place for the supply of medicines to patients' family/carer for administration while away from the home. Registered nurses continued to sign the medication administration records and had not recorded the transfer of the medicines to the family/carer. A recommendation was made.

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. It was agreed that obsolete warfarin dosage directions would be cancelled and archived.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Storage space for medicines was limited. However, medicines were observed to be 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

The registered provider should ensure that updates on the personal medication records are verified and signed by two registered nurses. A recommendation was made.

The registered provider should review the systems in place for the management of medicines for periods of absence from the home. Records of transfer to the family/carer should be maintained. Registered nurses should not record that they have administered the medicine. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.4 Is care effective?

Most of the medicines examined at this inspection had been administered in accordance with the prescriber's instructions. However, the wrong eye preparation had been administered for one patient since 20 June 2016. Registered nurses were requested to refer this to the prescriber for guidance and to follow the home's protocol for investigating and reporting medication incidents. A requirement was made.

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 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. Care plans were maintained. The reason for and the outcome of administration had not been recorded. A recommendation was made.

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 tool was used as needed. A care plan was maintained. 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 included details of the fluid consistency. Care plans and speech and language assessment reports were in place. Registered nurses and care staff maintained records of administration.

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.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for medicines which were not contained within the blister pack system.

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

Areas for improvement

The registered provider must investigate the error noted in the administration of one eye preparation. A report of the findings and action taken to prevent a recurrence must be forwarded to RQIA. A requirement was made.

The registered provider should ensure that the reason for and outcome of each administration of medicines prescribed to be administered when required for distressed reactions are recorded on all occasions. A recommendation was made.

Number of requirements	1	Number of recommendations	1

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.

We spoke with one patient who advised that the “staff were great” and “that the food was lovely, just the right amount”. The patient advised that a review of her medication was planned.

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, they had been updated in May 2015. 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.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. The registered nurses advised that if a discrepancy is identified, the registered manager would investigate and develop an action plan to prevent a recurrence.

Following discussion with the 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. They advised that any resultant action was communicated with all registered nurses.

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 this QIP were discussed with Ms Bernie Camilo, Nurse in Charge, 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 The 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 taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to *pharmacists@rqia.org.uk* for review 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

Statutory requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 28 July 2016	The registered provider must investigate the error observed in the administration of one eye preparation. A report of the findings and action taken to prevent a recurrence must be forwarded to RQIA. **Response by registered provider detailing the actions taken:** The error occurred with the label of the eye preparation . Nurses failed to check the label against the actual drug . An incident report was already submitted to the RQIA Nurse Manager had a meeting with the Pharmacist regarding error of labelling medications . Pharmacist and the Home agreed that a joint auditing of medications will be done quarterly to augment the monthly medications audit being done by the Home manager to minimise recurrence . The nurse who will receive the medications will thoroughly compare the labels done by the chemist against the actual medications .
Recommendations	
Recommendation 1 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 14 August 2016	The registered provider should ensure that updates on the personal medication records are verified and signed by two registered nurses. **Response by registered provider detailing the actions taken:** It is the Home's policy that two Nurses will sign hand written or updated personal medication records and this has always been followed until recently when one personal medication record was recently updated by a nurse but was not verified by a second nurse . Nurses were reminded to adhere to the Policy at all times. All updated personal medication records are now signed and verified by a nurse.
Recommendation 2 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 14 August 2016	The registered provider should review the systems in place for the management of medicines during periods of absence from the home as detailed in the report. **Response by registered provider detailing the actions taken:** System was already in placed for recording medications given to the family for administration while away from the Home.

Recommendation 3 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 14 August 2016	The registered provider should ensure that the reason for and outcome of each administration of medicines prescribed to be administered when required for distressed reactions are recorded on all occasions.
	Response by registered provider detailing the actions taken: The reason for and outcome of each administration of medicines prescribed to be administered when required for distressed reactions are now recorded at the back of Medications Administration Record Sheet.

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

The Regulation and Quality Improvement Authority

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