Unannounced Medicines Management Inspection Report
25 July 2017

Scrabo Isles

Type of Service: Nursing Home
Address: 61 Manse Road, Newtownards, BT23 4TP
Tel No: 028 9181 2231
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 35 beds that provides care for patients with a number of care needs (See Table 3.0).

3.0 Service details

Organisation/Registered Provider: Tona Enterprises Ltd **Responsible Individual(s):** Mr Robert Maxwell Duncan	**Registered Manager:** Ms Annalyn Depayso
Person in charge at the time of inspection: Ms Annalyn Depayso	**Date manager registered:** 27 March 2009
Categories of care: Nursing Home (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	**Number of registered places:** 35

4.0 Inspection summary

An unannounced inspection took place on 25 July 2017 from 10.40 to 13.55.

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 medicines management, record keeping, medicines storage and the management of controlled drugs.

One patient said, “This is a great home; you couldn’t ask for better care.”

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 Ms Annalyn Depayso, Registered 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 care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 7 June 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; it was ascertained that no incidents involving medicines had been reported 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, one relative, three care assistants 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
- medicine audits
- controlled drug record book
- care plans
- 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 7 June 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP 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 14 July 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**
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: The investigation was completed. An incident report form was submitted detailing the action taken to prevent a recurrence.	
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**
Recommendation 1 **Ref:** Standard 29 **Stated:** First time	The registered provider should ensure that updates on the personal medication records are verified and signed by two registered nurses.	**Met**
	Action taken as confirmed during the inspection: Updates on the personal medication records had been verified and signed by two registered nurses.	

Recommendation 2 **Ref:** Standard 29 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Accurate records of the transfer of medicines for administration outside the home were maintained.	
Recommendation 3 **Ref:** Standard 18 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: We reviewed the records for four patients. Care plans were in place. There had been no recent administrations. The registered manager advised that all registered nurses are aware that the reason for and outcome of any administration must be recorded in the daily progress notes.	

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.

The registered manager confirmed that all registered nurses had received training and been deemed competent to manage medicines. Training was updated annually via e-learning. Competency assessments were also completed annually. Care assistants were provided with training on the administration of thickening agents and application of emollient preparations as part of their induction.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. 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 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.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed via e-learning within the last year.

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.

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

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. Medicine refrigerators and oxygen equipment were checked at regular intervals. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The registered manager was reminded that prophylactic liquid antibiotics must be discarded at their expiry.

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

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. 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. 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 registered manager confirmed that these medicines were rarely used and that if required the reason for and the outcome of administration would be recorded in the daily progress notes.

The management of pain was reviewed. The registered manager confirmed that pain assessments were completed as part of the admission process. 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. The registered manager advised that a pain assessment tool was used with patients who were unable to verbalise their pain. Detailed care plans were in place.

The management of swallowing difficulty was examined. Care plans and speech and language reports were in place. Records of administration were maintained. For a few patients the thickening agent had not been recorded on the personal medication records; they were updated during the inspection.

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. The registered manager and registered nurses were commended for the standard of maintenance of the personal medication records and the medication administration records. A small number of personal medication records had not been cancelled and archived; the registered manager advised that this would be addressed after the inspection.

Running stock balances were maintained for medicines which were not supplied in the blister pack system, including liquids and inhalers. In addition a monthly audit was completed by the registered manager.

Following discussion with the registered manager, 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.

We spoke with three patients who were happy with how their medicines were managed.

One patient said that she "could not say enough about the staff and care provided in the home."

We spoke with one relative who was also complimentary about the care provided for her husband. She said that, "Staff were very kind and very patient."

Of the questionnaires that were issued, three were returned from patients, three from relatives and five from staff. The responses indicated that they were very satisfied with all aspects of the care in relation to the management of medicines.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Areas of good practice

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 available in the treatment room.

The registered manager confirmed that staff knew how to identify and report incidents and 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. The registered manager confirmed that if a discrepancy was identified, staff would be made aware and that any learning would be shared.

Following discussion with the registered manager and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Care assistants confirmed that any concerns in relation to care were raised with management. They advised that any resultant action was communicated with all staff for improvement.

Areas of good practice

There were examples of good practice in relation to governance arrangements 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.

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.

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