Somerton Private Nursing Home
RQIA ID: 1296
77 Somerton Road
Belfast
BT15 4DE

Inspector: Cathy Wilkinson
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Unannounced Medicines Management Inspection of Somerton Private Nursing Home

6 January 2016

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced medicines management inspection took place on 6 January 2016 from 10:50 to 12:25.

The management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no areas of concern. A Quality Improvement Plan (QIP) was not included in this report.

This inspection was underpinned by the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

1.1 Actions/Enforcement Taken Following the Last Medicines Management Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last inspection on 16 January 2015.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Somerton Private Nursing Home Henry Enda McCambridge Paul Henry McCambridge	**Registered Manager:** Ms Lynda Burton
Person in Charge of the Home at the Time of Inspection: Ms Lynda Burton	**Date Manager Registered:** 17 July 2013
Categories of Care: NH-DE	**Number of Registered Places:** 26
Number of Patients Accommodated on Day of Inspection: 20	**Weekly Tariff at Time of Inspection:** £593

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and to determine if the following standards and themes have been met:

Standard 28: Management of Medicines
Standard 29: Medicines Records
Standard 31: Controlled Drugs

Theme 1: Medicines prescribed on a "when required" basis for the management of distressed reactions are administered and managed appropriately.

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately.

4. Methods/Process

Specific methods/processes used included the following:

The management of incidents reported to RQIA since the last medicines management inspection was reviewed.

We met with the registered manager and staff on duty.

The following records were examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records (MARs)
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 19 August 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Inspection

Last Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that refrigerator temperatures are maintained within the required range of 2^{o}C and 8^{o}C.	**Met**
	Action taken as confirmed during the inspection: The refrigerator temperatures had been maintained within the required range.	
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that the controlled drug cabinet is rigidly and securely fixed to a wall or floor in accordance with The Misuse of Drugs (Safe Custody) (NI) Regulations 1973.	**Met**
	Action taken as confirmed during the inspection: The controlled drugs cabinet had been securely fixed.	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

Medicines were administered in accordance with the prescriber's instructions. The majority of medicines were contained within a blister pack system. The audit trails performed on a variety of randomly selected medicines that were not contained in the blister pack system provided satisfactory outcomes.

Areas of good practice included protocols for "when required" medicines, recording a running balance of medicines which were not contained in the blister pack system, and the routine recording of the date of opening of medicines, which facilitated the audit process.

The process for the ordering and receipt of medicines was reviewed. Prescriptions were received into the home and checked for accuracy with the monthly drug order. Medicines were only ordered as needed and there were systems in place to ensure that there was a continuous supply of medicines.

At the time of the inspection, medicines were prepared immediately prior to their administration from the container in which they were dispensed. All of the medicines examined at the inspection were labelled appropriately. In use insulin had been labelled and dated once opened.

Medicine records were generally well maintained so as to ensure that there was a clear audit trail. Records of the ordering, receipt, administration, non-administration and disposal of medicines were maintained. All of the personal medication records examined were written and signed by two registered nurses, this is safe practice. MARs sheets had been fully and accurately completed.

The receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Stock reconciliation checks were performed on controlled drugs which require safe custody, at each transfer of responsibility.

There were arrangements in place for the disposal of medicines which were discontinued or were unsuitable for use. There was evidence that controlled drugs were denatured prior to disposal using denaturing kits.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines including Standard Operating Procedures for controlled drugs were in place. These were not examined in detail.

Medicines were managed by staff who had been trained and deemed competent to do so, following a period of induction. The impact of training was monitored through team meetings, supervision and annual appraisal. A sample of records was provided. General medicines management training was completed regularly. A list of the names, signatures and initials of registered nurses was maintained.

Practices for the management of medicines were audited on a regular basis. Running stock balances were maintained for medicines which were not included in the 28 day blister packs. The community pharmacist had also completed audits. Satisfactory outcomes had been achieved.

There were procedures in place to report and learn from any medicine related incidents that had occurred in the home. The reported incident had been managed satisfactorily.

Is Care Compassionate? (Quality of Care)

The records relating to two of patients who were prescribed medicines on a “when required” basis for the management of distressed reactions were observed. The parameters for administration were recorded on the personal medication records. Care plans were maintained and evaluated monthly. The audits indicated that these medicines were administered infrequently. A reason for the administration and the outcome of the administration was recorded on each occasion that medicines were administered. From discussion with the staff, it was concluded that staff were familiar with the circumstances to administer anxiolytic medicines. Staff had the knowledge 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.

Medicines which were prescribed to manage pain were recorded on the patient's personal medication record. Examination of the medicine administration records indicated that these medicines had been administered as prescribed. This included regularly prescribed controlled drug patches and analgesics which were prescribed for administration on a "when required" basis. From discussion with the registered nurses, it was evident that staff were aware of the signs, symptoms and triggers of pain in patients. Where pain controlling medicines were prescribed, staff were aware that ongoing monitoring is necessary to ensure the pain was well controlled and the patient was comfortable. Care plans and pain assessment tools were maintained and evaluated each month.

Areas for Improvement

None identified

Number of Requirements	**0**	**Number of Recommendations**	**0**

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Lynda Burton	**Date Completed**	09/02/16
Registered Person	Paul McCambridge	**Date Approved**	09/02/16
RQIA Inspector Assessing Response	Cathy Wilkinson	**Date Approved**	11/02/2016

Please provide any additional comments or observations you may wish to make below:

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

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the service. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations.