Unannounced Medicines Management Inspection Report
18 January 2017

Strathearn Court

Type of Service: Nursing Home
Address: 229 Belmont Road, Belfast, BT4 2AH
Tel no: 028 9065 6665
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Strathearn Court took place on 18 January 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 working relationship with the community pharmacist, 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. One area of improvement was identified in relation to the recording of thickening agents and a recommendation was 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. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed Ms Susan Curry and Ms Kathleen Rebelo, Nursing Sisters, 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 most recent inspection on 28 November 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Mrs Ruth Murphy
Persons in charge of the home at the time of inspection: Ms Susan Curry and Ms Kathleen Rebelo (Nursing Sisters)	**Date manager registered:** 1 April 2005.
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 55

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 three patients, the two nursing sisters, one registered nurse and three care assistants.

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 28 November 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 11 November 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time	The registered person must closely monitor the administrations of five medicines in order to ensure that the prescribers' instructions are being complied with.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed, in the QIP response, that the administrations of the five medicines had been closely monitored on a weekly basis to ensure the prescriber's instructions were being complied with. Audits performed during this inspection produced broadly satisfactory outcomes.	

Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The dose of Humulin M3 insulin, prescribed for one patient, must be clearly specified on the personal medication record and medication administration record.	**Met**
	Action taken as confirmed during the inspection: Insulin doses were clearly specified on the personal medication records and medication administration records.	
Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time	The medication administration record must always be accurately completed.	**Met**
	Action taken as confirmed during the inspection: Medication administration records were observed to have been completed in a satisfactory manner.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The level of medication audit activity should be intensified on the first floor.	**Met**
	Action taken as confirmed during the inspection: Medication audits were performed on a daily, weekly and monthly basis.	
Recommendation 2 **Ref**: Standard 28 **Stated:** First time	Untidy personal medication record sheets should be rewritten.	**Met**
	Action taken as confirmed during the inspection: The personal medication record sheets had been rewritten when necessary.	
Recommendation 3 **Ref**: Standard 28 **Stated:** First time	The registered manager should review the arrangements for recording the administrations of analgesics that are prescribed for administration of variable doses, in order to ensure that the record is always clear and unambiguous.	**Met**
	Action taken as confirmed during the inspection: The arrangements for recording the administrations of analgesics that were prescribed for administration of variable doses had been reviewed in order to ensure the record was always clear and unambiguous.	

Recommendation 4 **Ref**: Standard 39 **Stated:** First time	Tubes of creams and ointments should be appropriately segregated.	**Met**
	Action taken as confirmed during the inspection: Tubes of creams and ointments were appropriately segregated.	

4.3 Is care safe?

Medicines were managed by staff who had 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 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 generally 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 and discharge from the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. 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. The use of separate administration charts was acknowledged.

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. The medicine refrigerator 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 largely been administered in accordance with the prescriber's instructions. One medicine discrepancy was drawn to the attention of the nursing sisters, who gave an assurance that the administrations would be closely monitored to ensure compliance with the dosage directions. 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. The reason for and the outcome of administration were generally recorded. A care plan was maintained.

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, care plans and speech and language assessment reports were in place. However, the thickening agent was not always recorded on the personal medication record and the consistency was generally not recorded on the medicine administration records and food and fluid intake charts. A recommendation was made.

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. Areas of good practice were acknowledged. These included the use of transdermal patch application records.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some solid dosage medicines not contained in the monitored dosage system blister packs. In addition, a periodic audit was completed by the community pharmacist.

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

Areas for improvement

The arrangements for the recording of thickening agents should be reviewed; a recommendation was made.

Number of requirements	0	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. Patients spoken to stated that they were very satisfied with the care experienced.

As part of the inspection process, we issued questionnaires to patients, patients' representatives and staff. One patient's representative completed and returned a questionnaire within the specified timeframe. Comments received were very positive; the responses were recorded as 'very satisfied' with the management of medicines in the home.

Four members 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. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them.

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 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 nursing sisters, registered nurse and care assistants, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

The requirements and recommendations made at the last medicines management inspection had been addressed.

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 Susan Curry and Ms Kathleen Rebelo, Nursing Sisters, 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 web portal 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

Statutory requirements

Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 17 February 2017	The registered provider should ensure that the arrangements for the recording of thickening agents are reviewed.
	Response by registered provider detailing the actions taken: Thickening agents are now recorded on the personal medication record. The consistency of the thickener is now recorded on the medicine administration records and on the food and fluid charts. Completion of these charts will be monitored through the internal monitoring system and by the Regional Manager on her regulatory visits to the Home.

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