Unannounced Medicines Management Inspection Report
13 July 2016

47 Somerton Road

Type of Service: Nursing Home
Address: 47 Somerton Road, Belfast, BT15 3LH
Tel No: 028 9077 2483
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of 47 Somerton Road took place on 13 July 2016 from 10:00 to 14:10.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

There was evidence that the management of medicines supported the delivery of safe care and promoted the delivery of positive outcomes for patients. Staff were trained and competent and there were robust processes for the management of medicines changes and management of high risk medicines. No requirements or recommendations were made.

Is care effective?

There was evidence that the management of medicines supported the delivery of effective care for patients. There were systems in place to ensure that the patients were administered their medicines as prescribed. Robust arrangements were in place for the management of pain and distressed reactions. No requirements or recommendations were 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 were 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 robust systems to manage and share any learning from medicine related incidents and areas identified within the audit process. No requirements or recommendations were 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.

1.1 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 were discussed with Mrs Jackie Montgomery, Nurse in Charge, as part of the inspection process and can be found in the main body of the report. Findings were also discussed with Mr Wayne Salvatierra, Registered Manager, via a telephone call on 15 July 2016.

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 21 June 2016.

2.0 Service details

Registered organisation/registered provider: Somerton Homes Ltd Mr William Trevor Gage	**Registered manager:** Mr Wayne Salvatierra
Person in charge of the home at the time of inspection: Mrs Jackie Montgomery (Nurse in Charge)	**Date manager registered:** 16 December 2015
Categories of care: NH-LD	**Number of registered places:** 38

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 spoke with two patients, three 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 21 June 2016

The most recent inspection of the home was an unannounced care inspection. The report was issued to the home on 14 July 2016 and the completed QIP will be reviewed by the care inspector when it is returned.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 24 July 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time	The time recorded for the administration of bisphosphonate medicines must be accurate.	**Met**
	Action taken as confirmed during the inspection: The nurse in charge confirmed that these medicines have been administered in accordance with the manufacturers' recommendations; however, the records of administration suggest that they have been administered with the morning medicines. The registered manager advised that this would be discussed with all registered nurses and monitored as part of his audit activity. Due to these assurances the requirement has not been restated.	

Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that records for the administration of thickening agents and external medicines by care staff are fully and accurately maintained.	**Met**
	Action taken as confirmed during the inspection: We confirmed that these records were being maintained on the home's computerised recording system.	
Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that all controlled drugs in Schedule 2, 3 and 4 (part 1), are denatured and therefore rendered irretrievable prior to disposal.	**Met**
	Action taken as confirmed during the inspection: The nurse in charge was unable to confirm if all controlled drugs in Schedule 2, 3 and 4 (part 1) were denatured prior to disposal as this activity is carried out by the registered manager and deputy manager. The registered manager confirmed that all controlled drugs in Schedule 2, 3 and 4 (part 1) were denatured prior to disposal. He agreed that this would be recorded on the disposal records.	
Requirement 4 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that records for the receipt of medicines for respite care are accurately maintained in order to facilitate a clear audit trail.	**Met**
	Action taken as confirmed during the inspection: We confirmed that the records were being accurately maintained.	
Requirement 5 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that the temperature of the refrigerator is maintained between 2°C and 8°C and that the thermometer is reset each day after the readings have been taken.	**Met**
	Action taken as confirmed during the inspection: The records for the daily refrigerator temperatures indicated that this practice was being followed.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 37 **Stated:** First time	The registered manager should ensure that the home's policies, including SOPs for controlled drugs, are comprehensive and cover each of the activities concerned with the management of medicines.	**Met**
	Action taken as confirmed during the inspection: The home's policies had been updated in September 2014. It was agreed that they would be further reviewed and revised due to recent changes in the medication system being used.	
Recommendation 2 **Ref:** Standard 37 **Stated:** First time	The registered manager should develop and implement an audit tool which covers all aspects of the management of medicines.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that a monthly audit was completed by the deputy manager. This was unavailable during the inspection	
Recommendation 3 **Ref:** Standard 37 **Stated:** First time	The reason for, and outcome of each administration of medicines to manage distressed reactions should be recorded on all occasions.	**Met**
	Action taken as confirmed during the inspection: The records for two patients were reviewed and this practice was in place.	

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 following induction only; it was agreed that competency assessments would be completed at least annually. Refresher training on medicines management had been provided in June 2016. Update training on the use of thickening agents had also been provided in June 2016.

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 medication 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 and discharge from the home. This was reviewed for two patients who had been admitted for respite care.

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. insulin. The use of separate administration charts was acknowledged.

Appropriate arrangements were in place for administering medicines in disguised form. The registered manager and nurse in charge confirmed that this had been authorised by the prescriber and that the suitability of adding the medicines to food/drinks had been confirmed with the community pharmacist. The family had been consulted.

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. However, the three oxygen cylinders available were not chained to prevent them falling over and an uncovered mask was observed. The registered manager agreed to address this issue without delay.

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, 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, 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 reason for and the outcome of administration were recorded in the daily progress notes.

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 only some patients could verbalise their pain, and a pain assessment tool was used when necessary. Care plans were 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 required fluid consistency. Care plans and speech and language assessment reports were in place. Each administration was recorded. Staff advised that a list of each patient's dietary requirements was available in the kitchen and dining room. However, in addition to the current list, an out of date list was available in the kitchen and obsolete speech and language assessments were available in the dining room. This was addressed during the inspection and discussed with the registered manager for close monitoring.

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. They included additional records for transdermal patches.

Practices for the management of medicines were audited throughout the month by the staff and management. The majority of medicines were contained within the blister pack system. Running stock balances were maintained for all solid dosage medicines which were not contained within the blister pack system.

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

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

Appropriate arrangements were in place to facilitate patients responsible for the self-administration of medicines.

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 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. The registered manager agreed these would be reviewed and updated to reflect the recent changes to the home's medication system.

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.

Records of the monthly audits were not available at the inspection. The registered manager advised that largely satisfactory outcomes were being achieved. He advised that if a discrepancy was identified, it would be investigated and discussed with staff for learning.

Following discussion with the registered manager, registered nurses and care staff, 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 in a mostly satisfactory manner. To ensure that these are fully addressed and the improvements sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

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, either on an individual basis or through staff meetings.

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

No areas for improvement were identified during the inspection. A QIP is therefore not included with this inspection report.

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.

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