# Unannounced Medicines Management Inspection Report
# 9 July 2018

# 47 Somerton Road

**Type of Service: Nursing Home**
**Address: 47 Somerton Road, Belfast, BT15 3LH**
**Tel No: 028 9077 2483**
**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 40 beds that provides care for patients who are living with a learning disability. The home provides care on a respite and permanent basis.

## 3.0 Service details

| | |
|---|---|
| **Organisation/Registered Provider:**<br>Somerton Homes Ltd<br><br>**Responsible Individual(s):**<br>Mr William Trevor Gage | **Registered Manager:**<br>Mr Wayne Salvatierra |
| **Person in charge at the time of inspection:**<br>Ms Jackie Montgomery, Nurse-in-charge | **Date manager registered:**<br>16 December 2015 |
| **Categories of care:**<br>Nursing Home (NH):<br>LD – learning disability | **Number of registered places:**<br>40 |

## 4.0 Inspection summary

An unannounced inspection took place on 9 July 2018 from 10.30 to 14.55.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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 administration, care planning, medicine storage and the management of controlled drugs.

Two areas for improvement were identified in relation to personal medication records and records of medicines disposal.

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 | 2 |

Details of the Quality Improvement Plan (QIP) were discussed with Ms Jackie Montgomery, 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.

## 4.2 Action/enforcement taken following the most recent premises inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 22 May 2018. 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
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA 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 six patients, one domestic assistant, one care assistant, the administrator and two registered nurses.

We provided the person in charge with 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. We also left 'Have we missed you' cards in the foyer of the home to inform patients/their representatives, how to contact RQIA to tell us of their experience of the quality of care provided.

We asked the person in charge to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

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
- care plans
- training records
- medicines storage temperatures

Areas for improvement 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 22 May 2018

The most recent inspection of the home was an announced premises inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at the next premises inspection.

## 6.2 Review of areas for improvement from the last medicines management inspection dated 10 July 2017

| Areas for improvement from the last medicines management inspection | | |
|---|---|---|
| **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** |
| **Area for improvement 1**<br><br>**Ref**: Standard 18<br><br>**Stated:** First time | The registered person shall review and revise the management of distressed reactions as detailed in the report.<br><br>**Action taken as confirmed during the inspection**:<br>Detailed care plans were in place. The reason for and outcome of each administration were recorded in the daily progress notes. | **Met** |
| **Area for improvement 2**<br><br>**Ref**: Standard 4<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 August 2017 | The registered person shall review and revise the management of pain as detailed in the report.<br><br>**Action taken as confirmed during the inspection**:<br>Care plans were in place which were reviewed regularly. Details of how patients expressed their pain were included. Pain assessment tools were used with patients who could not verbalise their pain. | **Met** |

## 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.**

Medicines were managed by staff who have been trained and deemed competent to do so. Training had been provided by the community pharmacist and an external training company within the last year. Records were available for inspection. Competency assessments were also completed annually. The registered manager advised (via telephone call on 18 July 2018) that care assistants had received training and been deemed competent to administer thickening agents and emollient preparations.

In relation to safeguarding, the nurse in charge advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training had been provided in March 2018.

There were systems in place to ensure that medicines were available for administration on all occasions. Prescriptions were received into the home and checked against the order before being forwarded to the pharmacy for dispensing. Antibiotics and newly prescribed medicines had been received into the home without delay.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and to manage medication changes. Personal medication records and hand-written entries on the medication administration records were verified and signed by two registered nurses. This safe practice was acknowledged. Registered nurses advised that medicine dosage regimens were confirmed with the prescriber before each period of respite care.

Robust arrangements were observed for the management of high risk medicines e.g. insulin. The use of separate administration charts was acknowledged. Dates of opening were recorded on all insulin pens to facilitate audit and disposal at expiry. However one insulin pen remained in use after expiry. This was replaced during the inspection and registered nurses advised that this would be brought to the attention of all registered nurses for vigilance. Due to the assurances provided an area for improvement was not specified at this time.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. The name of the controlled drug had not been recorded on a small number of pages in the controlled drug book, this was brought to the attention of the registered nurses for correction and ongoing vigilance. Checks were performed on controlled drugs which require safe custody, at the end of each shift.

Satisfactory arrangements were in place for the safe disposal of discontinued or expired medicines.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were well organised. Satisfactory recordings were observed for the daily refrigerator temperatures.

**Areas of good practice**

There were examples of good practice in relation to staff training, competency assessment and the management of medicines on admission.

**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 alternate day, twice weekly and weekly medicines were due.

The management of distressed reactions and pain was reviewed and found to be satisfactory (see Section 6.2).

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. Records of prescribing and administration, which included the recommended consistency levels, were appropriately maintained.

Registered nurses confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on a patient's health were reported to the prescriber.

The majority of the medicine records were well maintained and facilitated the audit process. However, it was noted that the allergy status had not been documented on several personal medication records and that obsolete personal medication records had not been cancelled and archived. In addition, the date of disposal of medicines had not always been recorded and the disposal records had not been verified and signed by two registered nurses. Two areas for improvement were identified.

The majority of medicines, including liquids, were supplied in the blister pack system. Running stock balances were maintained for medicines which were prescribed to be administered "when required" or were not suitable to be packaged in the blister pack system. In addition the community pharmacist completed an audit at approximately quarterly intervals.

Following discussion with the registered nurses and care assistant, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in patient care.

**Areas of good practice**

There were examples of good practice in relation to care planning and the administration of medicines.

**Areas for improvement**

The allergy status of each patient should be recorded on the personal medication records. Obsolete personal medication records should be cancelled and archived.

Records of disposal should include the date of disposal and entries should be verified and signed by two registered nurses.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 0 | 2 |

**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.**

We observed the administration of medicines to a small number of patients. The registered nurse engaged the patients in conversation and explained that they were having their medicines.

Throughout the inspection, it was found that there were good relationships between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity. It was clear from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. The patients spoken to at the inspection seemed to be content. Some patients were looking forward to going out to the shops and for a coffee. Other patients had been shopping and were showing their purchases to staff. There was a list of the planned activities available on the notice board.

As part of the inspection process, we issued 10 questionnaires to patients and their representatives, none were returned within the specified time frame.

Any comments from patients, their representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for information and action as required.

**Areas of good practice**

Staff were observed to listen to patients and to take 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.**

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. Arrangements were in place to implement the collection of equality data within 47 Somerton Road.

Written policies and procedures for the management of medicines were in place. These were not examined in detail.

There were robust arrangements in place for the management of medicine related incidents. Registered nurses confirmed that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, they advised that they were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were examined. Management advised of the auditing processes completed by staff and management and how areas for improvement were detailed in an action plan, shared with staff/unit managers to address and systems in place to monitor improvement.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with the registered manager or responsible individual.

The staff we met with spoke positively about their work and advised there were good working relationships in the home with staff and the registered manager. They stated they felt well supported in their work.

We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date. In addition to verbal handovers, a communications diary was in use.

Staff advised that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with all staff without delay.

No online questionnaires were completed by staff with the specified time frame (two weeks).

**Areas of good practice**

There were examples of good practice in relation to governance arrangements, the management of medicine incidents 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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Jackie Montgomery, Nurse-in-charge, and Mr Wayne Salvatierra, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

## 7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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.

## 7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed via the Web Portal for assessment by the inspector.

## Quality Improvement Plan

| **Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015** | |
|---|---|
| **Area for improvement 1**<br><br>**Ref**: Standard 29<br><br>**Stated:** First time<br><br>**To be completed by:**<br>9 August 2018 | The registered person shall ensure that the allergy status of each patient is recorded on personal medication records and that obsolete personal medication records are cancelled and archived.<br><br>Ref: 6.5<br><br>**Response by registered person detailing the actions taken:**<br>Allergy status of each patient is updated on 30/07/18 and obsolete personal medication records have been cancelled and archived. Memo issued on the 27/07/18 that only updated personal medication records will be filled in the Medication Administration Folder and old one will be archived. |
| **Area for improvement 1**<br><br>**Ref**: Standard 29<br><br>**Stated:** First time<br><br>**To be completed by:**<br>9 August 2018 | The registered person shall ensure that records of disposal include the date of disposal and are verified and signed by two registered nurses.<br><br>Ref: 6.5<br><br>**Response by registered person detailing the actions taken:**<br>Memo was put on for all nurses on 27/07/18 that medicine disposal must be verified and signed by two registered nurses at all times. |

***Please ensure this document is completed in full and returned via the Web Portal***

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