Unannounced Medicines Management Inspection Report
10 July 2017

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 38 beds that provides care for patients with a learning disability on both a permanent and respite basis.

3.0 Service details

Organisation/Registered Provider: Somerton Homes Ltd **Responsible Individual(s):** Mr William Trevor Gage	**Registered Manager:** Mr Wayne Salvatierra
Person in charge at the time of inspection: Mrs Mel Briones (Deputy Manager)	**Date manager registered:** 16 December 2015
Categories of care: Nursing Home (NH) LD – learning disability.	**Number of registered places:** 38

4.0 Inspection summary

An unannounced inspection took place on 10 July 2017 from 10.10 to 13.35.

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 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 staff training, the management of medicines on admission, the standard of record keeping and the administration of medicines.

Areas requiring improvement were identified in relation to care plans for the management of distressed reactions and pain.

Patients said that they were “very happy in the home and that staff were lovely”.

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 Mrs Mel Briones, Deputy Manager, 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 care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 14 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 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 four patients, the domestic assistant, two care assistants, a registered nurse and the deputy 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
- controlled drug record book
- medicine audits
- care plans
- training records
- medicines storage temperatures

There were no areas for improvement identified at the last medicines management inspection.

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 14 June 2017

The most recent inspection of the home was an unannounced care inspection. The draft report and QIP have been issued. The completed QIP will be reviewed by the care inspector when it is returned and will be validated at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 13 July 2016

There were no areas for improvement made as a result of the last medicines management inspection.

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 deputy manager confirmed that medicines were managed by staff who have been trained and deemed competent to do so. Registered nurses attended medicines management training in January 2017. Competency assessments were completed annually. An induction process was in place for registered nurses and for care staff who had been delegated medicine related tasks. Training on dysphagia had been provided in April 2017.

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, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed in April 2017.

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. Additional checks were also performed on other controlled drugs which is good practice.

Mostly satisfactory arrangements were observed for the management of high risk medicines e.g. insulin. The use of separate administration charts was acknowledged. However dates of opening had not been recorded on three out of six in-use insulin pens. The deputy manager and registered nurse were reminded that dates of opening should be recorded to facilitate audit and disposal at expiry. It was agreed that this would be highlighted to all registered nurses.

Appropriate arrangements were in place for administering medicines in disguised form. A care plan was in place.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

The majority of medicines were stored safely and securely and in accordance with the manufacturer's instructions. Although space was limited medicine storage areas were clean, tidy and well organised. Medicine refrigerators and oxygen equipment were checked at regular intervals. The mouthpiece cover for one inhaler was missing and the spacer device needed to be replaced; this was addressed at the inspection.

Areas of good practice

There were examples of good practice in relation to staff training, 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 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, 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. Care plans were in place but they did not provide detail on how the distressed reaction should be managed and when the medication should be administered. For a small number of patients these medicines were being administered regularly. The reason for and outcome of administration had not been recorded on several occasions. This had been identified at a previous inspection and had been addressed at the last medicines management inspection but the improvements made had not been sustained. An area for improvement was identified.

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 pain, and a pain tool was used as needed. Care plans were in place but they did not provide detail on why the patient required pain relief, how they expressed pain and what medicines were prescribed. An area for improvement was identified.

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 fluid consistency. Care plans and speech and language assessments were in place. Each administration was recorded.

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 the standard of maintenance of the personal medication records and the separate recording systems for the administration of insulin and transdermal patches.

Practices for the management of medicines were audited throughout the month by the deputy manager. In addition running stock balances were maintained for medicines which were not contained in the blister pack system.

Following discussion with the deputy manager and staff, 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 and the administration of medicines.

Areas for improvement

The registered person shall ensure that detailed care plans are in place for the management of distressed reactions. The reason for and outcome of administration should be recorded on all occasions. The regular administration of "when required" medicines should be referred to the prescriber for review.

The registered person shall ensure that detailed care plans are in place for the management of pain. The cause of the pain and details of what medicines are prescribed should be recorded. Details of how each patient expresses pain should be recorded where possible.

	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 medicines being administered to two patients. The administration was completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible.

Patients were observed to be relaxed and comfortable. One patient who was upset was being comforted by staff. Appropriate music was then played and patients began to have a sing-a-long. One patient was being helped with her knitting and plans were being made to go to the local shopping centre.

Fifteen questionnaires were left in the home to facilitate feedback from patients, staff and relatives. Three were returned from patients, two from relatives and two from staff. All responses were positive with regards to the management of medicines. Two comments required follow up and these were discussed with management within the home. One relative made the following comment, “As my son is very well looked after in the home, I have complete confidence in the staff who at all times are compassionate, competent and very caring.”

During conversations patients made the following comments:
“I am very happy here.”
“I’m part of the furniture.”
“I love getting to the shops and staff are lovely.”
“The food is lovely, I’m going to get whatever I want for lunch.”

We spoke to two care assistants who said that they “just loved working in the home with the patients.”

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 in place. These were not reviewed at the inspection. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There were robust arrangements in place for the management of medicine related 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. In relation to the regional safeguarding procedures, staff confirmed that they 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 deputy manager advised that any discrepancies would be investigated and discussed with staff for learning.

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

Staff confirmed that any issues could be brought to the management team who would address them. The most recent staff meeting had taken place in April 2017.

Areas of good practice

There were examples of good practice in relation to 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 Mrs Mel Briones, Deputy 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 QIP to Pharmacists@rqia.org.uk for assessment by the inspector.

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.

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 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 10 August 2017	The registered person shall review and revise the management of distressed reactions as detailed in the report.
	Response by registered person detailing the actions taken: Care plan for distressed reaction was amended on 29/07/17 as detailed in the report.
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 10 August 2017	The registered person shall review and revise the management of pain as detailed in the report.
	Response by registered person detailing the actions taken: Care plan for pain management was amended on 29/07/17 as detailed in the report.

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

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