Unannounced Medicines Management Inspection Report
1 November 2017

The Somme

Type of Service: Nursing Home
Address: 121 Circular Road, Belfast, BT4 2NA
Tel No: 028 9076 3044
Inspector: Paul Nixon

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 50 beds that provides care for patients with a variety of healthcare needs, as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Board of Directors **Responsible Individual:** Mr Charles Jonathan Kitson	**Registered Manager:** Mrs Leigh Patience
Person in charge at the time of inspection: Ms Ruth Rogers (Deputy Manager)	**Date manager registered:** 29 June 2017
Categories of care: Nursing Homes (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of registered places:** 50

4.0 Inspection summary

An unannounced inspection took place on 1 November 2017 from 09.40 to 14.50.

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 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 medicine administration, medicines storage and the management of controlled drugs.

Areas requiring improvement were identified in relation to medicine records and care planning.

The patients we spoke with were complimentary about the management of their medicines and the care provided in the home.

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	1	*1

*The total includes one area for improvement under standards which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Ms Ruth Rogers, 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 30 May 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- 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

During the inspection we met with three patients, the home administrator, the deputy manager, one registered nurse and three care staff.

A total of 10 questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views 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

The area for improvement identified at the last medicines management inspection was 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 30 May 2017

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 the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 4 January 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 **Ref**: Standard 4 **Stated:** First time	The registered provider should ensure that detailed care plans are in place when medicines are prescribed to be administered on a 'when required' basis for the management of distressed reactions.	**Not met**
	Action taken as confirmed during the inspection: The records belonging to three patients were examined. For two patients, the care plan did not specify the circumstances under which the medicine was to be administered in managing the distressed reaction. **This area for improvement has been stated for a second time.**	

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 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. 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 largely satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses, which is considered safe practice. However, this did not always occur for handwritten medicine administration records. The deputy manager gave an assurance that this matter would be rectified.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

There were procedures in place to ensure the safe management of medicines during a patient's admission to 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.

Robust arrangements were observed for the management of high risk medicines e.g. insulin and warfarin. 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. The medicine refrigerator and oxygen equipment were checked at regular intervals. Several insulin pens did not have the date of opening recorded; the deputy manager gave an assurance that this matter would be rectified.

Areas of good practice

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

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.

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. However, discrepancies were noted in the audit trails performed on a small number of medicines. The deputy manager gave an assurance that these medicines would be closely monitored.

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 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. However, as stated in section 6.2, for two of three patients whose records were examined a detailed care plan, specifying the circumstances under which the medicine was to be administered, was not in place. An area for improvement was stated for a second time.

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. A pain assessment tool was used as needed. A care plan was maintained.

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. Administrations were recorded and care plans and speech and language assessment reports were in place.

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. Several patients regularly refused to take their medication; the nursing staff stated that the General Medical Practitioners were aware of this.

Medicine records were generally well maintained and facilitated the audit process. However, the allergy status of some patients was not recorded on their personal medication record sheets. An area for improvement was identified. Also, where a patient had more than one personal medication record sheet in current use, this was not recorded on each sheet; the deputy manager gave an assurance that this matter would be rectified.

Practices for the management of medicines were audited by the staff and management. This included running stock balances for most psychoactive medicines. The last medication audit carried out by management was on 25 October 2017. A periodic audit was completed by the community pharmacist, the last having occurred in October 2017.

Following discussion with the deputy manager and staff, 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 found throughout the inspection in relation to the administration of most medicines, the completion of most records and care planning. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

One area for improvement under standards has been stated for a second time in relation to care planning (See section 6.2).

The medicine allergy status of each patient must be recorded on their personal medication record.

	Regulations	Standards
Total number of areas for improvement	1	0

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 five patients. The registered nurses administering the medicines spoke to the patients in a kind and caring manner and the patients were given time to swallow their medicine.

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. From discussion with and observation of staff, it was clear that the staff were familiar with the patients' likes and dislikes.

The patients spoken to at the inspection, advised that they had no concerns in relation to the management of their medicines, they preferred the registered nurses to administer their medicines and their requests for medicines prescribed on a 'when required' basis were adhered to e.g. pain relief. They were complimentary regarding staff and management. Comments included:

"It's very good here; the staff are pleasant, the food is good."
"It's great here; the staff are very helpful."
"The care is excellent; staff are very kind."

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.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the listening to and taking account of the views of patients.

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. 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. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the audit records indicated that largely 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 and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

The area for improvement identified at the last medicines management inspection had not been addressed effectively. To ensure that these are fully addressed and the improvement 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 management were open and approachable and willing to listen.

Areas of good practice

There were examples of good practice in relation to the management of medicine incidents. 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 Ruth Rogers, Deputy Manager, as part of the inspection process and also with Mrs Leigh Patience, Registered Manager via telephone on 2 November 2017. 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 Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 1 December 2017	The registered person shall ensure that the medicine allergy status of each patient is recorded on their personal medication record. Ref: 6.5
	Response by registered person detailing the actions taken: These were all updated for each resident on the day of inspection and are audited weekly to ensure full compliance.
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 4 **Stated:** Second time **To be completed by:** 1 December 2017	The registered provider should ensure that detailed care plans are in place when medicines are prescribed to be administered on a 'when required' basis for the management of distressed reactions. Ref: 6.2 and 6.5
	Response by registered person detailing the actions taken: These were updated for all residents in receipt of medication for distressed reactions and are evaluated on each occasion the medication is required or monthly which ever is most frequent

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

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