Unannounced Medicines Management Inspection Report
14 June 2017

Spa Nursing Home

Type of Service: Nursing Home
Address: 77-79 Grove Road, Ballynahinch BT24 8PW
Tel No: 028 9756 2578
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 36 beds that provides both nursing and residential care.

3.0 Service details

Organisation/Registered Provider: Spa Nursing Homes Ltd **Responsible Individual:** Mr Christopher Arnold	**Registered Manager:** Ms Jocelyn Leyson-Bagood
Person in charge at the time of inspection: Ms Tracy Molloy	**Date manager registered:** 12 August 2009
Categories of care: Nursing Home (NH) TI – terminally ill PH – physical disability other than sensory impairment I – old age not falling within any other category PH(E) - Physical disability other than sensory – over 65 years Residential Care (RC) 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	**Number of registered places:** 36

4.0 Inspection summary

An unannounced inspection took place on 14 June 2017 from 10.30 to 13.40.

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 term ‘patients’ is used to describe those living in Spa Nursing Home which provides both nursing and residential care.

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, medicine records, storage and the management of controlled drugs.

No areas for improvement were identified.

One patient commented that they “would like to thank the staff.”

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Tracy Molloy, Nurse in Charge, as part of the inspection process and can be found in the main body of the report.

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 31 August 2016.

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 incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

During the inspection we met with one patient, one care assistant and two registered nurses.

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
- medicine audits
- care plans
- medicines storage temperatures
- controlled drug record book

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 31 August 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 the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 5 May 2016

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 37 **Stated:** Second time	The registered manager should ensure that the reason for the administration of medicines for the management of distressed reactions and subsequent outcome are recorded in the patient's daily progress notes on every occasion.	**Met**
	Action taken as confirmed during the inspection: New recording sheets were in place. The reason for and outcome of administration of "when required" medicines were being recorded.	
Area for improvement 2 **Ref:** Standard 31 **Stated:** First time	The management of controlled drugs should be reviewed and revised as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The management of controlled drugs had been reviewed and revised. Each administration was witnessed and signed by both members of staff.	

Area for improvement 3 **Ref:** Standard 18 **Stated:** First time	Detailed care plans should be in place when patients are prescribed medicines for administration on a "when required" basis for the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: A review of the records indicated that these care plans were in place. The need to refer regular administration to the prescriber for review was discussed with the registered nurses.	

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 nurse in charge advised that update training was provided annually by the community pharmacist. Competency assessments were completed annually by the registered manager. The impact of training was monitored through the home's audit process. Care assistants received training on the administration of thickening agents and emollient preparations as part of their induction.

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 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. However, one audit indicated that the dosage directions for one medicine had been transcribed incorrectly. This had not been identified by the registered nurse who had countersigned the personal medication record. Registered nurses who had then administered the medicine had not identified the discrepancy between the personal medication record and the medicine label. The nurse in charge was requested to contact the prescriber for guidance. It was agreed that the accuracy of all transcriptions would be closely monitored.

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. warfarin. The use of separate administration charts was acknowledged. The registered nurses on duty were reminded that obsolete warfarin dosage directions should be cancelled and archived.

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.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medication changes 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 majority of medicines examined had been administered in accordance with the prescriber's instructions. Discrepancies in two inhaled medicines were discussed and it was agreed that inhaled medicines would continue to 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 and 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. 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 being recorded.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place. 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.

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 assessment reports were in place. Each administration was recorded.

Appropriate arrangements were in place for managing medication refusals. 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. Registered nurses were reminded that the strength and dose of each medicine should be clearly recorded. Areas of good practice were acknowledged. They included the prompts for weekly medicines.

Practices for the management of medicines were audited throughout the month by the staff. The records and medicines for between five and eight patients were audited each month. In addition nutritional supplements were audited daily.

Following discussion with the registered nurses, 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, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 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 one patient. It was completed in a caring manner. The time of administration had been changed to ensure compliance.

Fifteen questionnaires were left in the home to facilitate feedback from patients, staff and relatives. Eight were returned within the time frame; three from patients, one from a relative and four from staff. All responses were positive.

Patients were observed to be relaxed and comfortable. Staff interactions were caring. Patients were being assisted to the day room and staff were helping with lunch.

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.

Staff confirmed that they knew how to identify and report 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. 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 registered nurses and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff either individually or via team meetings.

Areas of good practice

There were examples of good practice in relation to governance arrangements 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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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