Unannounced Medicines Management Inspection Report
9 February 2017

Tennent Street

Type of Service: Nursing Home
Address: Sandringham Suite, 1 Tennent Street, Belfast, BT13 3GD
Tel no: 028 9031 2318
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Tennent Street (Sandringham Suite) took place on 9 February 2017 from 10.30 to 13.00.

The inspection sought to assess progress with any issues raised during and since the previous 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 positive outcomes for patients. Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. There were no areas of improvement identified.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Specific areas of medicines management were detailed in the patients' care plans. There were no areas of improvement identified.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for patients. Patients consulted with confirmed that they were administered their medicines appropriately. There were no areas of improvement identified.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. There were no areas of improvement identified.

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 Jacquelyn Woods, Registered Manager, 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.

1.2 Actions/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection in the nursing units at Tennent Street on 28 and 29 July 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/ Dr Maureen Claire Royston	**Registered manager:** Mrs Jacquelyn Grace Woods
Person in charge of the home at the time of inspection: Mrs Jacquelyn Grace Woods	**Date manager registered:** 1 April 2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 17

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 met with two patients, two members of care staff, one registered nurse and the registered manager.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

Twenty questionnaires were issued to patients, relatives/patient representatives and staff, with a request that these were completed and returned to RQIA within one week of the inspection.

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 28 and 29 July 2016

The most recent inspection of the home was an unannounced care inspection. No requirements or recommendations were made.

4.2 Review of requirements and recommendations from the last medicines management inspection 1 May 2014

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should develop a care plan regarding the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: This area of medicines management had been reviewed. Training had been provided. Care plans were maintained and reviewed on a regular basis.	

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 annually. Refresher training in medicines management was provided in the last year. Training also included the management of syringe drivers, administration of medicines via enteral feeding tubes and the management of distressed reactions.

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.

Robust arrangements were observed for the management of high risk medicines e.g. insulin. A care plan was maintained.

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.

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.

It was acknowledged that safe systems for medicines management continued to be in place as identified at this and the previous medicines management inspection and there was evidence over time of positive outcomes for patients.

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 twice weekly or three monthly medicines were due.

A staff communication book was maintained and viewed at each shift change. This included information regarding medicines and the outcomes of visits from/consultation with other healthcare professionals.

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.

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. A care plan was maintained. 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. There was evidence that any increased frequency in use of these medicines had been reported to the prescriber.

The management of pain was examined. Staff advised that a pain assessment was completed for all patients at the time of admission to the home and on a regular basis. The patient's pain management was detailed in the care plans examined. The sample of medicine records examined indicated that pain controlling medicines had been administered as prescribed. Staff were aware of the need to ensure that the pain was well controlled and the patient was comfortable.

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. Each administration was recorded and care plans and speech and language assessment reports were in place.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for transdermal patches and analgesics. Protocols in relation to medicines which are prescribed on a 'when required' basis were also maintained.

Following discussion with the registered manager and staff, and review of the care files, it was evident that when applicable, other healthcare professionals were contacted in response to the patients' healthcare needs.

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?

The administration of medicines to patients was not required during the time of the inspection and was therefore was not observed.

However, following discussion with staff, it was confirmed that patients were given time to take their medicines and medicines were administered as discreetly as possible. It was evident that staff were familiar with the patients' likes and dislikes.

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.

The patients spoken to had no concerns regarding the management of their medicines and advised that staff responded in a timely manner to any requests for pain relief or care.

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, questionnaires were issued to patients, relatives/patients' representatives and staff. One questionnaire was completed and returned by one relative/patient's representative. The responses were recorded as 'satisfied' with medicines management in the home.

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. These were not examined 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. 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.

A comprehensive auditing system for medicines management was in place. It included daily, weekly and monthly audits. Running stock balances were maintained for a number of medicines. An overarching audit was completed by the registered manager every month and in addition audits were completed by the community pharmacist. A review of the internal audit records indicated that satisfactory outcomes had been achieved. Staff advised of the procedures undertaken if any discrepancies or areas for improvement were identified.

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 staff spoken to at the inspection were very positive about their work, the relationships between staff and the support provided by the staff team and the registered manager. They advised that the registered manager was always available and willing to listen.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated at shift handover, team meetings and through the use of the communication book.

It was acknowledged that robust systems for medicines management were in place and the evidence indicated that this has promoted the delivery of positive outcomes for patients over time.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of 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.

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews