Unannounced Medicines Management Inspection Report
10 June 2016

Victoria

Type of Service: Nursing home
Address: 22 -24 Windsor Park, Belfast, BT9 6FR
Tel No: 208 9066 8437
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Victoria took place on 10 June 2016 from 09:50 to 14:30.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern though one area for improvement was identified and is set out in the quality improvement plan (QIP) within this report.

Is care safe?
No requirements or recommendations were made.

Is care effective?
One recommendation regarding the management of distressed reactions was made.

Is care compassionate?
No requirements or recommendations were made. .

Is the service well led?
No requirements or recommendations were made.

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	1

Details of the QIP within this report were discussed with Ms Helen Chambers, Registered 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.

1.2 Actions/enforcement taken following the most recent care inspection

A serious concerns meeting took place following the most recent care inspection (7 April 2016) to discuss the inspection findings and the home's action plan to address the concerns identified by RQIA.

2.0 Service details

Registered organisation/registered person: Dr Robert Francis Alistair Lynas & Mrs Helen Lynas	**Registered manager:** Ms Helen Frances Chambers
Person in charge of the home at the time of inspection: Ms Helen Chambers	**Date manager registered:** 20 November 2008
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 33

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, the deputy manager, two registered nurses, two care assistants and the head chef.

A sample of the following records was examined:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 April 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 20 May 2013

Last medicine management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** Third time	The necessary arrangements must be made to ensure that: • the temperatures are maintained within the accepted range of +2^{o}C to +8^{o}C • a system is in place to report any deviation in temperature to the registered manager.	**Met**
	Action taken as confirmed during the inspection: The temperature of the medicines' refrigerator had been maintained within the required range. The registered manager confirmed that staff are aware of the need to highlight any issues regarding the refrigerator.	
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that all nurses are provided with training in the cold storage of medicines.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that training had been completed following the last medicines management inspection and that it is included in the ongoing medicines management training.	
Requirement 3 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must put robust systems in place for the record keeping and disposal of controlled drugs.	**Met**
	Action taken as confirmed during the inspection: The controlled drug record book was maintained in a satisfactory manner. Two registered nurses were involved in the administration and disposal of controlled drugs.	

Last medicines management inspection recommendation		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	Written Standard Operating Procedures (SOPs) for the management of controlled drugs should be developed and implemented.	**Met**
	Action taken as confirmed during the inspection: Written Standard Operating Procedures (SOPs) for the management of controlled drugs had been developed and implemented. A copy was provided for inspection.	

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, group supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was provided for registered nurses in the last week. The registered manager advised that training on the administration of thickening agents and emollients was provided for care staff as part of their induction and ongoing thereafter.

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.

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.

The management of warfarin was reviewed. Dosage directions were received in writing, transcribing involved two staff and stock balances were maintained. Despite these practices there had been a recent incident. A review of the recording systems indicated that there were too many documents in use. This was rectified during the inspection. Obsolete dosage directions were cancelled and archived and a single document to record the new dosage directions, dose administered and running balance was developed. The registered manager confirmed that this system would be discussed with all registered nurses and monitored closely. No further action is required at this time.

Appropriate arrangements were in place for administering medicines in disguised form. Authorisation from the prescriber and family had been obtained and a care plan was in place. The community pharmacist had been consulted on the suitability of adding the medication to liquid/food.

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

Storage space for medicines was limited; the registered manager confirmed that this was being reviewed as part of the home's improvement plans. Medicines were stored safely and securely and in accordance with the manufacturer's instructions. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. However, the date of opening had not been recorded on all eye drops and this was discussed for immediate corrective action. Medicine refrigerators and oxygen equipment were checked at regular intervals.

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?

With the exception of two inhaled medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. The registered manager and deputy manager provided assurances that inhaled 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, 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, 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, however; detailed care plans were not in place and the reason for, and the outcome of, administration were not recorded on all occasions. For one patient the medicine was being administered every night and this had not been reviewed with the prescriber.
A recommendation was made.

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 most of the patients could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment tool is completed as part of the admission process.

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. Administration was recorded on the daily diet charts.

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.

Practices for the management of medicines were audited throughout the month by both staff and management. This included running stock balances for several solid dosage medicines, nutritional supplements and inhaled medicines. In addition, a monthly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas for improvement

The management of distressed reactions should be reviewed to ensure that:

- detailed care plans are in place
- the reason and outcome of administration are recorded on all occasions
- regular administration is referred to the prescriber for review

A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

The administration of medicines was completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible.
The medicine round did not finish until 11.00. The registered manager advised that this had been reviewed following the recent care inspection. With the exception of time critical medicines, the morning medicines are administered in the dining room when patients come down for their breakfast. The actual time of administration is now recorded to ensure that dosage intervals are not compromised. Patients attend for breakfast at a time of their preference. The breakfast routine was calm and patients seemed relaxed in their environment with some remaining for a second cup of tea/coffee. The registered manager advised that in order to assist the morning medication round registered nurses are no longer expected to take phonecalls at that time and that a senior carer is on duty to answer queries from care assistants where possible.

We spoke with two patients who advised that they were content in the home and that staff were very good. The patients advised that they could ask for additional pain relief when required.

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.

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. Management advised that these were reviewed regularly. 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 review of the home's 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 manager, 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 all staff either individually or through team meetings.

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

The issue identified during this inspection is detailed in the QIP. Details of this QIP were discussed with Ms Helen Chambers, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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 your premises. 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and DHSSPS Care Standards for Nursing Homes (2015). They promote current good practice and if adopted by the registered provider may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered provider

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered provider will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to pharmacists@rqia.org.uk and assessed by the inspector.

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 person/manager from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 13 July 2016	The management of distressed reactions should be reviewed and revised as detailed in the report.
	Response by registered person detailing the actions taken: careplans for clients on diazepam were written on 13th june 2016 and are reviewed monthly.

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

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