Unannounced Medicines Management Inspection Report
12 June 2017

Victoria

Type of Service: Nursing Home
Address: 22 – 24 Windsor Park, Belfast, BT9 6FR
Tel No: 028 9066 8437
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 33 beds that provides both residential and nursing care.

3.0 Service details

Organisation/Registered Provider: Dr Robert Francis Alistair Lynas Mrs Helen Lynas	**Registered Manager:** Ms Helen Frances Chambers
Person in charge at the time of inspection: Ms Helen Frances Chambers	**Date manager registered:** 20 November 2008
Categories of care: Nursing Care (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 Residential Care (RC): I – old age not falling within any other category	**Number of registered places:** 33 Category RC-I for 1 identified individual only

4.0 Inspection summary

An unannounced inspection took place on 12 June 2017 from 10.10 to 14.55.

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 Victoria, 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 the administration of medicines and the standard of maintenance of the personal medication records.

Areas requiring improvement were identified in relation to the admission process, the management of controlled drugs, the covert administration of medicines and the auditing arrangements 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	3	1

Details of the Quality Improvement Plan (QIP) 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.

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 28 February 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 we met with two patients, one visitor, two registered nurses and the registered 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
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

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 28 February 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 10 June 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 18 **Stated:** First time	The management of distressed reactions should be reviewed and revised as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The management of distressed reactions had been reviewed and revised. Care plans were in place. The registered manager confirmed that the reason for and outcome of each administration would be recorded in the progress notes. There had been no recent administrations.	

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.

Registered nurses had received training on the management of medicines in January 2017. Competency assessments were updated annually; they were currently being reviewed with all registered nurses. Appraisals had been completed in May 2017. Records were provided for inspection. Refresher training in the management of medicines via the enteral route had been provided for registered nurses in March 2017. The registered manager confirmed that care assistants received training on the administration of thickening agents and emollient preparations as part of their induction.

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 January 2017.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. There was evidence that 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.

We reviewed the admission process for three patients. The currently prescribed medicines had been confirmed in writing with the prescribers. The personal medication records and medication administration records had been written and verified by two registered nurses. This safe practice was acknowledged. However, for two patients the records of administration were not accurate; the audits indicated that the medicines had been administered as prescribed. For the third patient, the initial supply of medicines had been accurately received into the home, however additional supplies of loose strips of three medicines had then been received. These medicines had not been recorded as received and hence the audits could not be completed. The registered person should review the admission process with all registered nurses to ensure that accurate records of receipt and administration are maintained. An area for improvement was identified.

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. However, controlled drugs were not being denatured and rendered irretrievable prior to disposal. The registered person should review the disposal arrangements for controlled drugs. An area for improvement was identified.

The management of medicines via a gastrostomy tube was reviewed and found to be mostly satisfactory. A detailed regimen was in place and a fluid intake chart detailing the start and stop time of the feed and water flushes was maintained. It was agreed that the recommended daily fluid intake would be recorded on the regimen.

Medicines were being administered covertly. This had been authorised by the prescriber. However the care plan did not detail which medicines could be administered covertly and how they should be administered. The registered person should review the arrangements for the administration of medicines in disguised form to ensure that detailed care plans are in place. An area for improvement was identified.

The majority of medicines were stored safely and securely and in accordance with the manufacturer's instructions. Some nutritional supplements were observed to be out of date. This was addressed during the inspection and the registered manager advised that this would be closely monitored as part of the home's auditing system. 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 and the management of medication changes.

Areas for improvement

The registered person shall review the admission process with all registered nurses to ensure that accurate records of receipt and administration are maintained.

The registered person shall review the disposal arrangements for controlled drugs. Controlled drugs must be denatured prior to disposal.

The registered person shall review the arrangements for the administration of medicines in disguised form to ensure that detailed care plans are in place.

	Regulations	Standards
Total number of areas for improvement	2	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The majority of the medicines examined had been administered in accordance with the prescriber's instructions. Audit discrepancies were however observed for two liquid medicines and audits could not be completed for two inhaled medicines as the dates of opening had not been recorded. As part of an overall increase in the home's auditing system the registered person should closely monitor the administration of liquid medicines and inhaled medicines to ensure that these medicines are being administered as prescribed. An area for improvement with regards to the home's auditing system was identified in Section 6.7.

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.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were maintained. There was evidence that pain assessments were completed as part of the admission process. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable.

The management of swallowing difficulty was examined for two patients. The prescribed thickening agents were recorded on the personal medication records and included details of the fluid consistency. Care plans and speech and language assessments were in place. Registered nurses maintained records of administration on the medication administration records. Care assistants recorded administration on the daily fluid intake 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. The need to document and follow up all refusals was discussed in detail.

The personal medication records had been written and updated by two registered nurses. This safe practice was acknowledged. Improvements in the standard of maintenance of the medication administration records were necessary. There were several missed signatures for administration; the audits indicated that the medicines had been administered. As part of an overall increase in the home's auditing system (See Section 6.7) the registered person should closely monitor the standard of completion of the medication administration records.

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 of good practice

There were examples of good practice in relation to care planning and the administration of the majority of medicines.

Areas for improvement

The registered person should monitor the administration of liquid medicines and inhaled medicines and the completion of the medicine administration records (see Section 6.7).

	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.

The registered manager advised that appropriate arrangements were in place to facilitate patients responsible for the self-administration of medicines. No patients were currently responsible for managing any of their prescribed medicines.

We observed some patients receiving their medicines in the dining room. Patients were given time to take their medicines and registered nurses were kind and courteous.

Fifteen questionnaires were left in the home to facilitate feedback from patients, staff and relatives. Eleven were returned within the timeframe from patients, relatives and staff who advised that they were satisfied/very satisfied with how medicines were managed in the home.

We spoke with two patients who were complimentary of the care and food provided in the home.

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.

	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. The registered manager advised that they were due for review on 29 June 2017. It was agreed that the controlled drug policy would be updated to state that controlled drugs are denatured prior to disposal.

The registered manager advised that she regularly audited the management of medicines. The records of management audits, seen at the last medicines management inspection were no longer in place. Running stock balances for some medicines not contained within the blister pack system were being maintained. As stated in Section 6.5 audit discrepancies were identified in the administration of some liquid medicines. Some inhaled medicines could not be audited as dates of opening had not been recorded. The registered person should implement a robust auditing system to monitor all aspects of medicines management, including the administration of medicines not supplied in the monitored dosage system and the standard of completion of the medication administration records. An area for improvement was identified.

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, the registered manager confirmed that all staff were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

Following discussion with the registered manager and the registered nurses, it was evident that staff should receive additional training on the admission process, the management of controlled drugs, the covert administration of medicines and the maintenance of accurate medication administration records. The registered manager advised that the findings of the inspection would be discussed with all registered nurses at the planned meeting on 14 June 2017.

Registered nurses confirmed that any concerns in relation to medicines management could be raised with management. They advised that any resultant action was communicated with registered nurses at handovers.

Areas of good practice

Medication incidents had been managed appropriately. In addition, staff had begun to address the shortfalls which were identified during the inspection.

Areas for improvement

The registered person shall implement a robust auditing system to monitor all aspects of medicines management, including the administration of inhaled medicines, liquid medicines and the standard of maintenance of the medication administration records.

	Regulations	Standards
Total number of areas for improvement	1	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 Helen Chambers, Registered 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 7 July 2017	The registered person shall review the admission process with all registered nurses to ensure that accurate records of receipt and administration are maintained.
	Response by registered person detailing the actions taken: This process has been reviewed and found to be appropriate. All nursing staff have been informed to follow this process on every occasion. Admissions from date of inspection have been checked and have been appropriately managed. This process will continue to be checked on every new admission.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 7 July 2017	The registered person shall review the disposal arrangements for controlled drugs. Controlled drugs must be denatured prior to disposal.
	Response by registered person detailing the actions taken: All nursing staff informed that controlled drugs must be denatured prior to disposal. Controlled drugs can not be returned to pharmacy untill they are denatured.
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 7 July 2017	The registered person shall implement a robust auditing system to monitor all aspects of medicines management, including those medicines not supplied in the monitored dosage system and the standard of completion of the medication administration records.
	Response by registered person detailing the actions taken: weekly spot checks are now carried out on all non blister packed medication. Records of findings maintained.
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 28 **Stated:** First time **To be completed by:** 7 July 2017	The registered person shall review the arrangements for the administration of medicines in disguised form to ensure that detailed care plans are in place.
	Response by registered person detailing the actions taken: care plans now clearly reflect covert medication.

***Please ensure this document is completed in full and returned to Pharmacists@rqia.org.uk ***

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