Unannounced Medicines Management Inspection Report
19 December 2016

Wheatfield House

Type of Service: Nursing Home
Address: 20 Wheatfield Gardens, Belfast, BT14 7HU
Tel no: 028 9039 1555
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Wheatfield House took place on 19 December 2016 from 10.20 to 13.45.

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. No requirements or recommendations were made.

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. Care plans regarding medicines management were in place. One area for improvement was identified in relation to record keeping and delegated tasks. A requirement was stated for a second time.

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. No requirements or recommendations were made.

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 which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. 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	1	0

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Alice Chisanga, Nurse in Charge and Mr Edward Mc Loughlin, Registered Provider/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

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 21 April 2016.

2.0 Service details

Registered organisation/registered person: Mr Edward John McLoughlin	**Registered manager:** Mr Edward John McLoughlin
Person in charge of the home at the time of inspection: Mrs Alice Chisanga until 11.30 and Mr Edward John McLoughlin thereafter	**Date manager registered:** 1 April 2005
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 22

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the incidents register – it was ascertained that there had been no medicines related incidents reported to RQIA since the last medicines management inspection.

We met with two patients, one member of senior care staff, one registered nurse and the registered provider/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 returned 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
- 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 21 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. This QIP will be validated by the care inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection on 16 October 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The registered manager must ensure that all Schedule 4 (Part 1) controlled drugs are denatured prior to disposal.	**Met**
	Action taken as confirmed during the inspection: Staff confirmed that any discontinued Schedule 4 (Part 1) controlled drugs were denatured by two registered nurses using a doom kit prior to disposal.	
Requirement 2 **Ref**: Regulation 19(3) **Stated:** First time	The registered person must ensure that records of staff training and competency are readily available for inspection at all times	**Met**
	Action taken as confirmed during the inspection: Records of staff training and competency assessments were provided at the inspection.	

Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must ensure that where care staff are responsible for the administration of external preparations and thickening agents, accurate records of administration are maintained.	**Partially Met**
	Action taken as confirmed during the inspection: This area of medicines management requires further improvement. Although the majority of external preparations were administered by the care staff, records were completed by the registered nurses; they did not oversee the administration of the external preparations on each occasion. This was further discussed in relation to accountability and that staff should only sign for medicines which they administer. In relation to thickening agents, there were no administration records in place for two patients. This requirement is stated for a second time.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 18 **Stated:** First time	It is recommended that the management of medicines in relation to distressed reactions is reviewed to ensure that the increased frequency in use is reported to the prescriber, the outcome of each administration is recorded and the relevant care plan includes reference to the medicine.	**Met**
	Action taken as confirmed during the inspection: The management of distressed reactions had been reviewed and the relevant records were in place.	
Recommendation 2 **Ref**: Standard 4 **Stated:** First time	It is recommended that the management of medicines for patients who attend day care settings should be reviewed, to ensure the specific arrangements are clearly recorded in their care plan and medicines are administered as prescribed.	**Met**
	Action taken as confirmed during the inspection: Staff advised of the procedures which had been undertaken after the last medicines management inspection, which had resulted in a medicines review with the prescriber. Medicines were no longer required to be sent to the day centre.	

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 usually completed annually. These were due to be completed for 2016. In the last year, refresher training in epilepsy was provided and e-learning in medicines management was completed.

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. Two medicines were out of stock on the day of the inspection and staff confirmed that they were ordered and would be delivered in the evening.

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.

Some medicines were administered in disguised form. A care plan was in place.

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. 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 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 three times weekly, 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 recorded. A care plan was maintained.

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 some of the patients could verbalise pain, and a pain assessment tool was used as needed. Details of pain management were recorded in the care plans examined. A separate pain chart was used to record the location of the patient's pain and the effect of the analgesia. This is good practice.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on only one of the three personal medication records examined. The prescribed fluid consistency was not recorded. It was agreed that this would be recorded after the inspection. Care plans and speech and language assessment reports were in place and there were 'placemats' detailing this information to assist staff in preparing the thickened fluids. However, records of administration were incomplete and there was no system in place to enable care staff to record administration. This element of the requirement made at the last medicines management inspection was stated for a second time.

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 majority of medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for insulin administration. However, as detailed in Section 4.2, the administration of external preparations requires review. There was evidence that a folder for external preparations had been developed; however, this was not in use. This was further discussed regarding accountability and a system to ensure that staff sign for the medicines they administer. This element of the requirement made at the last medicines management inspection is stated for a second time.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines, nutritional supplements and sachets.

Following discussion with the registered provider/manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to medicines management.

Areas for improvement

The records pertaining to external preparations and thickening agents must be reviewed to ensure they are fully and accurately maintained. A requirement was stated for a second time.

Number of requirements	1	Number of recommendations	0

4.5 Is care compassionate?

The administration of medicines to patients was not observed during the inspection.

The administration of medicines was discussed and staff confirmed that patients were given time to take their medicines and medicines were administered in accordance with their preferences.
The patients spoken to advised that they had no concerns regarding the management of their medicines and were complimentary about the staff. There was evidence of good relationships with staff. Comments included:

- "I love it here"
- "they look after me"
- "the staff are good"
- "I like all the chatting"

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 provided for patients, relatives/patient representatives and staff. One patient, one patient's relative/representative and five staff returned and completed questionnaires. The responses were recorded as 'very satisfied' with the management of medicines 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.

A review of the audit records indicated that satisfactory outcomes had been achieved. Where a discrepancy had been identified, staff advised of the action taken and how this was shared with staff to improve practice.

Following discussion with the registered provider/manager, registered nurses and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Not all of the requirements made at the last medicines management inspection had 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.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Alice Chisanga, Nurse in Charge and Mr Edward Mc Loughlin, Registered Provider, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager 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 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.

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 Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to the RQIA web portal for assessment 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 provider 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 provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4)	The registered person must ensure that where care staff are responsible for the administration of external preparations and thickening agents, accurate records of administration are maintained.
Stated: Second time **To be completed by:** 19 January 2017	**Response by registered provider detailing the actions taken:** All care staff have been advised and reminded to complete the file that is designated for the recording of the administration of external preparations and thickening agents and to ensure that accurate records are mainitained

Please ensure this document is completed in full and returned to the RQIA web portal

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