Unannounced Medicines Management Inspection Report
21 November 2017

Slemish Nursing Home

Type of Service: Nursing Home
Address: 28 Broughshane Road, Ballymena, BT43 7DX
Tel No: 028 2564 9772
Inspector: Frances Gault

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 45 beds that provides care for patients as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Healthcare Ireland (Belfast) Limited **Responsible Individual:** Ms Amanda Celine Mitchell	**Registered manager:** Mrs Dorothy McKeefry
Person in charge at the time of inspection: Mr Sreejith Mohandas, Clinical Nurse Lead who was joined later by Mrs Dorothy McKeefry, Registered Manager	**Date manager registered:** 27 January 2014
Categories of care: Nursing Homes 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:** 45

4.0 Inspection summary

An unannounced inspection took place on 21 November 2017 from 10.30 to 14.45. This was the first medicines management inspection since the change of ownership of the home.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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 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 record keeping and staff training.

No new areas for improvement were identified during the inspection. One area in relation to care plans for the administration of “when required” medicines was stated for a second time.

Patients were positive in their comments about the home and 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	1*

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Dorothy McKeefry, 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 required to be taken following the most recent inspection on 19 September 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 records:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents; It was ascertained that no incidents involving medicines had been 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 one patient, eight staff and three patients' visitors/representatives.

Ten questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

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
- policies and procedures
- care plans
- medicines storage temperatures

Areas for improvements 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 19 September 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 30 September 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 registered provider should ensure that the management of medicines prescribed for use "when required" for distressed reactions is reviewed to ensure that a care plan is in place and that the reason for and outcome of administration is recorded on every occasion.	**Not met**
	Action taken as confirmed during the inspection: Only one of these medicines had been administered in recent weeks. The reason for the administration had been documented on the medicine administration record.	

	However, although there was reference to the rationale for the prescribing, there was no care plan in place and no outcome was documented regarding the effect of the administration. This area for improvement will be stated for a second time.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered provider should ensure that the outcomes of all management of medicines audits and the QIPs from inspection activity are used as part of the manager's audit process.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that this had been addressed. There was evidence of the action taken to address the findings of a recent audit by the community pharmacist.	

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.

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 and supervision. The registered manager advised of the e-learning modules now in place as an outcome of the change in ownership.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Antibiotics 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. It was the expected practice that hand written personal medication records were updated by two registered nurses. However, this was not always the practice. The registered manager agreed to remind staff.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

There were procedures in place to ensure the safe management of medicines during a patient's admission to, 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 required safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Appropriate arrangements were usually in place for administering medicines through a PEG tube with authorisation provided by the prescriber.

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. Medicine refrigerators were checked at regular intervals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff, training, supervision, the management on medicines on admission/discharge, the storage of prescriptions and medicines.

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 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 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, specific 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, there was no care plan in place. The area for improvement stated at the last medicines management inspection was stated for the second time (see Section 6.2).

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.

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 were in place.

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 the staff and management. This included end of box audits for some medicines. In addition, a quarterly 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 the health needs of the patients.

Areas of good practice

There were examples of good practice found throughout the inspection in relation audits and reviews and communication between patients, staff and other key stakeholders.

Areas for improvement

No new areas for improvement were identified during the inspection. One area for improvement in relation to the administration of "when required" medicines was stated for the second time.

	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.

One patient was going out for the afternoon and said that she was looking forward to having her lunch in a favourite restaurant. The nurses gave her medicines to her relative to give during the trip.

Ten questionnaires were left in the home to facilitate feedback from patients, staff and relatives. Three were returned from relatives who advised that they were very satisfied with all aspects of the care in relation to the management of medicines. Patients and representatives were spoken with during the inspection. All expressed their satisfaction with the care provided in the home.

Relatives' comments:

- "Slemish Nursing Home is excellent. Since my mother went in I have been very satisfied with her care".
- "Staff are very warm and attentive"

One relative spoke of his delight in the improvement in the health of his relative during a period of respite following a hospital stay. He hoped that if the improvement continued, they would be able to return to their own home.

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. The care assistants were heard engaging in chat with the patients throughout the inspection.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing patients and taking account of the views of patients.

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.

New written policies and procedures for the management of medicines had been introduced with the change of ownership of the home. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

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.

The manager and nurses advised of an evening with their community pharmacist who had discussed the use of a monitored dosage system. A decision had been taken to commence a trial in part of the home. It was hoped that the use of the system would enable the staff to spend more time with the patients.

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 them.

Areas of good practice

There were examples of good practice in relation to staff awareness of roles and responsibilities and maintaining good working relationships.

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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Dorothy McKeefrey, 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 via the Web Portal for assessment by the inspector.

Quality Improvement Plan

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 18 **Stated:** Second time **To be completed by:** 0 November 2017	The registered provider should ensure that the management of medicines prescribed for use “when required” for distressed reactions is reviewed to ensure that a care plan is in place and that the reason for and outcome of administration is recorded on every occasion. Ref: 6.2 and 6.5
	Response by registered person detailing the actions taken: The management of medicines prescribed for use when required for distressed reactions has been reviewed and all residents prescribed such medicines now have a care plan in place which states the reason for administration and the outcome is recorded on every occasion.

Please ensure this document is completed in full and returned via the Web Portal

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