Unannounced Medicines Management Inspection Report
30 September 2016

Slemish House

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

1.0 Summary

An unannounced inspection of Slemish House took place on 30 September 2016 from 09:30 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. 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. One area of improvement was identified in relation to the management of distressed reactions and a recommendation was made.

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 which supported the delivery of care. One area of improvement was identified in relation to the audit process and a recommendation was 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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 standards until compliance is achieved. Please also refer to section 4.2 of this report.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report 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.

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 14 June 2016.

2.0 Service details

Registered organisation/registered person: Slemish House Ltd/Mr Christopher Walsh	**Registered manager:** Mrs Dorothy McKeefry
Person in charge of the home at the time of inspection: Registered nurse Ms Jackie Boyd McConville until the registered manager, Mrs Dorothy McKeefry arrived	**Date manager registered:** 27 January 2014
Categories of care: NH-I, NH-PH, NH-PH(E)	**Number of registered places:** 45

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- the management of medicine related incidents reported to RQIA since the last medicines management inspection.

We met with two patients, the deputy manager, one registered nurse, two care staff and one staff member.

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.

The following records were 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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 June 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 29 April 2014

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 13 (4) **Stated:** First time	The registered manager must ensure that the administration of external preparations by designated care assistants is accurately recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: The evidence seen indicated that care assistants knew the procedure and were completing the records.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should ensure that a second designated member of staff witnesses and signs the record for the disposal of medicines.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that this was practice within the home.	

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 appraisal. Competency assessments were completed annually. Refresher training in medicines management and the use of thickening agents (for care and catering staff) had been provided this year.

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.

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.

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

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Since the last medicines management inspection new medicine trolleys have been obtained which enable staff to separate the morning medicines from the others. The registered manager advised that this has improved the efficiency of the morning medicine round. 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 regularly.

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. It was noted that different times were documented on the personal medication record and administration record in relation to the administration of some time-critical medicines. The manager advised that nurses were aware of the importance of administering these medicines on time. It was agreed that the times documented would be reviewed. 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, 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 outcome of the administration was usually recorded. There was no evidence of a care plan in place. 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 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 highlighting when injections were due.

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 for improvement

It is recommended 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.

Number of requirements	0	**Number of recommendations**	1

4.5 Is care compassionate?

The vast majority of patients were in bed when the morning medicines were being administered. The registered nurse spent time in the privacy of the room to administer the medicines. The registered manager advised that this was seen as an opportunity for the nurses to discuss any current health issues with each patient.

We spoke to two patients during the inspection. Both were complimentary about their care, with one advising that the staff "were very good". One of the patients was prescribed regular analgesia and advised that she got this as it was prescribed. The second did not require any pain relief.

One of the administrative staff was observed taking a photograph of a new patient. She spent time chatting to the patient and explaining why the photograph was required. She sought his consent and once it was taken he was shown the photograph for approval.

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 in detail and the registered manager advised that they had all been reviewed within the last three years.

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.

All the audits relating to the management of medicines indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was no evidence of the action taken, although the registered manager advised that the outcomes were discussed with staff. It was recommended that the outcomes of all medicine audits and the QIPs from inspection activity should be used as part of the manager's audit process.

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 both the registered manager and deputy manager were very involved in all aspects of the management of medicines.

Areas for improvement

It was recommended that the outcomes of all medicine audits and the QIPs from inspection activity should be used as part of the manager's audit process.

Number of requirements	0	**Number of recommendations**	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Dorothy McKeefry, registered manager, 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 pharmacists@rqia.org.uk 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	
Recommendations	
Recommendation 1 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 31 October 2016	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. **Response by registered provider detailing the actions taken:** A Care Plan has been put in place for all Residents who are prescribed 'when required' medication, the reason for and outcome of administration is recorded on every occasion.
Recommendation 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 31 October 2016	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. **Response by registered provider detailing the actions taken:** All Management of medicine audits and the findings from inspection activity will be included in the Manager's audit process.

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

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