Unannounced Medicines Management Inspection Report
6 June 2016

Three Islands

Type of Service: Nursing Home
Address: 62-66 Main Street, Toomebridge, BT41 3NJ
Tel No: 028 7965 0650
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Three Islands took place on 6 June 2016 from 09.50 to 13.15.

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. A quality improvement plan (QIP) has not been included in this report.

Is care safe?
No requirements or recommendations have been made.

Is care effective?
No requirements or recommendations have been made.

Is care compassionate?
No requirements or recommendations have been made.

Is the service well led?
No requirements or recommendations have been 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	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mr David Joseph McAteer, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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 previous QIP there were no further actions required to be taken following the most recent inspection on 3 November 2015.

2.0 Service details

Registered organisation/registered person: Mr D McAteer and Mrs A McAteer	**Registered manager:** Mr David Joseph McAteer
Person in charge of the home at the time of inspection: Mr David Joseph McAteer	**Date manager registered:** 7 May 2009
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 40

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

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

We met with one patient and one registered nurse.

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
- Training records
- Medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 3 November 2015

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 16 May 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must make the necessary arrangements to ensure that bisphosphonate medicines are administered in accordance with the manufacturer's instructions.	**Met**
	Action taken as confirmed during the inspection: There was evidence that bisphosphonate medicines were administered at the correct time in accordance with the manufacturer's instructions.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standards 37,38 **Stated:** First time	The registered manager should review the management of medicines for distressed reactions to ensure the relevant records are being maintained.	**Met**
	Action taken as confirmed during the inspection: The record keeping pertaining to the management of distressed reactions had been reviewed. A care plan was maintained and the reason for and the outcome of any medicine administration was recorded in the daily notes. In recent weeks, a new form had been developed and implemented to record the administration of medicines administered on a "when required" basis. This was located with the patient's personal medication record and medication administration record.	

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 completed annually. Training was provided through attendance at training sessions and the completion of e-learning modules. Refresher training in general medicines management was provided in the last year. The most recent training was in relation to diabetes mellitus.

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 when the patient was temporarily absent from the home.

Epilepsy management plans were in place for the relevant patients.

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.

Robust arrangements were observed for the management of high risk medicines e.g. insulin. The use of a separate chart to indicate the site of administration was acknowledged.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. Staff were reminded that where medicines are denatured, this should be clearly recorded in the disposal record book.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. 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 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 weekly or three monthly medicines were due.

Satisfactory arrangements were in place for the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Staff advised that these medicines were rarely required; however, confirmed that they 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 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 where applicable. The management of pain was detailed in the patient's assessment record summary.

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 and speech and language assessment reports 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 running stock balances for several solid dosage medicines and nutritional supplements and inhaled 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 were contacted in response to any concerns regarding medicines management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

The administration of medicines to patients was completed in a caring manner. The patients were given time to take their medicines and medicines were administered as discreetly as possible.

Some medicines were administered with yoghurt to help the patient swallow their medicines. It was agreed that this arrangement would also be recorded in the patient's care plan and pharmaceutical advice would be sought regarding the suitably of adding medicines to food.

One patient advised that they had no concerns in relation to the management of their medicines, and that staff responded to any request for medicines prescribed on a "when required" basis. This patient spoke positively about the staff.

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 every few years. 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 internal 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 and registered nurse, 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 through team meetings or individually with staff.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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