Unannounced Medicines Management Inspection Report
16 June 2016

Prospect

Type of Service: Nursing Home
Address: 3 Old Galgorm Road, Ballymena, BT42 1AL
Tel No: 028 2564 5813
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Prospect took place on 16 June 2016 from 10.20 to 14.50.

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?

The management of medicines supported the delivery of safe care. 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. Two areas of improvement were identified in relation to the audit procedure for inhaler preparations and records regarding prescribed thickening agents. Two recommendations were made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely. 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. Systems were in place to enable management to identify and cascade learning from medicine audit activity. There were no areas of improvement identified.

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.

1.1 Inspection outcome

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

Details of the QIP within this report were discussed with Mrs Elizabeth Ross, 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 7 December 2015.

2.0 Service details

Registered organisation/registered person: Prospect Private Nursing Home Ltd/ Mr Thomas Mark McMullan	**Registered manager:** Mrs Elizabeth Jane Ross
Person in charge of the home at the time of inspection: Mrs Elizabeth Ross	**Date manager registered:** 1 April 2005
Categories of care: NH-I, NH-PH	**Number of registered places:** 52

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 no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with the registered manager, the deputy manager and three registered nurses.

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 7 December 2015

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 dated 5 February 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 inhaled preparations are being administered according to the prescriber's instructions and that medicine administration records are monitored to ensure compliance. The omissions must be reported to the prescriber and any further discrepancies must be reported to RQIA.	**Met**
	Action taken as confirmed during the inspection: Satisfactory outcomes were observed for four of the five inhaler preparations audited at the inspection. There was evidence that previous omissions had been discussed with the prescriber and the medicines reviewed. No further omissions had been reported since no discrepancies had been identified during audits undertaken by staff. However, the home's auditing system may not be effective in identifying discrepancies in the administration of inhaled medicines. This was discussed with the registered manager who agreed to revise and monitor the auditing system. The requirement as written has been met however a recommendation was made regarding audit procedures.	

Requirement 2 **Ref**: Regulation 13(4) **Stated:** Second time	The registered manager must ensure that robust arrangements are in place for the management and administration of insulin. Individual insulin pen devices must be labelled with the patients name, marked with the date of opening, stored and used according to the manufacturer's instructions and needles must be used once only and discarded immediately.	**Met**
	Action taken as confirmed during the inspection: Robust procedures were observed to be in place for the management and administration of insulin. All pen devices in use were individually labelled, marked with the date of opening and being stored and used appropriately. This area of medicines management was included in audit procedures and a revised procedure was in place which had been shared with registered nurses.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37 **Stated:** Second time	The registered manager should ensure that the management of anxiolytic medication prescribed for use 'when required' for distressed reactions is reviewed. Parameters for administration should be documented in the patients care plan and the reason for use and the outcome should be recorded in the daily notes.	**Met**
	Action taken as confirmed during the inspection: This area of medicines management had been addressed following the last inspection. A care plan was in place for the majority of patients. It was agreed that these would be completed for the remaining patients following the inspection. The reason for use and the outcome was usually recorded. It was discussed and agreed that this should be recorded on every occasion using one method consistently e.g. a written record or a record on the computer system where daily progress notes are recorded. Due to the assurances received and the progress made this requirement was not stated for a third time.	

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 care staff who had been delegated medicine related tasks. The impact of training was monitored through supervision and annual appraisal and a training matrix was in place. Competency assessments were completed annually. Refresher training in medicines management had last been provided for relevant staff in October and November 2015 by an external training company. This training included end of life care. Training on the use of syringe drivers was also provided for registered nurses in June 2015.

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 printed 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.

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 performed on other controlled drugs which is good practice.

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

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. It was discussed and agreed that when Schedule 4 (Part 1) controlled drugs are denatured prior to disposal this should be clearly recorded in the record of disposal, since although staff confirmed it had taken place, it was not always recorded.

Medicines were stored in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and 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 largely 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 robust 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, 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. A care plan was maintained for the majority of patients. It was agreed that these would be completed for the remaining patients following the inspection. The reason for use and the outcome was usually recorded. It was discussed and agreed that this should be recorded on every occasion using one method consistently e.g. a written record or a record on the computer system where daily progress notes are recorded.

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 where patients could not verbalise any pain, a pain assessment tool would be used if necessary. A care plan was maintained. Staff also advised that a pain assessment was completed as part of the admission process.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record but did not always include details of the prescribed fluid consistency. Although this information was available for staff reference this should be included on personal medication records. Care plans and speech and language therapy assessment (SALT) reports were in place. The prescribed consistency of fluid was not always recorded in the care plan and in one example the care plan did not correlate with the SALT report. A recommendation was made.

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. Areas of good practice were acknowledged.

Practices for the management of medicines were audited regularly by the registered nurses. In addition, quarterly audits were completed by the community pharmacist. It was recommended that the audit procedure for inhaled medicines should be reviewed and that these should be overseen by management to ensure that it is effective (see section 4.2). A recommendation was made.

It was evident that when applicable, other healthcare professionals were contacted regarding the management of medicines.

Areas for improvement

For those patients prescribed a thickening agent, the prescribed fluid consistency should be recorded on the personal medication record and in the care plan. These records should correlate with the most recent SALT report. A recommendation was made.

The audit procedure for inhaled medicines should be reviewed and should be overseen by management to ensure that it is effective. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

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

It was not possible to ascertain the views and opinions of patients since they were enjoying lunch and then attending a church service at this time, however patients 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. 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 in a change of practice.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents should they occur.

Following discussion with the registered manager and registered nurses, 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.

The requirements and recommendation made at the last medicines management inspection had been satisfactorily addressed. To ensure that the improvement is sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

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

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Elizabeth Ross, 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 the 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 taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to pharmacists@rqia.org.uk for review 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 28 **Stated:** First time **To be completed by:** 16 July 2016	The registered person should ensure that the audit procedure for inhaled medicines is reviewed and is overseen by management to ensure that it is effective.
	Response by registered person detailing the actions taken: Audits for inhalers reviewed and end of box and monthly audits to be completed by all staff. Management to review its effectiveness.
Recommendation 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 16 July 2016	The registered person should ensure that for patients prescribed a thickening agent, the prescribed fluid consistency is recorded on the personal medication record and in the care plan. These records should correlate with the most recent SALT report.
	Response by registered person detailing the actions taken: Records being reviewed to ensure all records are up to date and recorded accurately.

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

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