# Unannounced Medicines Management Inspection Report
# 5 October 2016

# Jordanstown

**Type of Service: Nursing Home**
**Address: 1a Old Manse Road, Jordanstown, BT37 0RU**
**Tel no: 028 9085 2258**
**Inspector: Rachel Lloyd**

## 1.0 Summary

An unannounced inspection of Jordanstown took place on 5 October 2016 from 09.40 to 14.10.

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 largely in compliance with legislative requirements and standards. One area for improvement was identified in relation to the management of medicines with a limited shelf life after opening. One requirement was made.

**Is care effective?**

The management of medicines largely supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Four areas of improvement were identified in relation to the facilitation of audit, the measurement of liquid medicine doses, the management of records for medicines prescribed for use "when required" to manage distressed reactions and care plans for the management of pain. Four 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 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. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and 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.

## 1.1 Inspection outcome

| | Requirements | Recommendations |
|---|---|---|
| **Total number of requirements and recommendations made at this inspection** | 1 | 4 |

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Jean Steele, 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 18 July 2016.

## 2.0 Service details

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| **Registered organisation/registered person:**<br>Four Seasons Healthcare<br>Dr Maureen Claire Royston | **Registered manager:**<br>Mrs Jean Elizabeth Steele |
| **Person in charge of the home at the time of inspection:**<br>Mrs Jean Steele | **Date manager registered:**<br>1 April 2005 |
| **Categories of care:**<br>NH-I | **Number of registered places:**<br>53 |

## 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.

We met with two patients, two registered nurses and the registered 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.

A sample of the following records was examined:

- 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 18 July 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and was 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 22 January 2015

There were no requirements or recommendations made as a result of the last medicines management inspection.

### 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. Refresher training in medicines management was provided for registered nurses in January 2016. Registered nurses had also received training in enteral feeding and the administration of medicines via this route since the last inspection.

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 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 also performed on other controlled drugs which is good practice.

Arrangements were examined for the management of high risk medicines e.g. anticoagulants and insulin. The use of separate administration charts was acknowledged. Written confirmation of warfarin administration regimes were usually received. When this was not possible, a second designated member of staff was involved in confirming and transcribing the prescribed doses.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. Staff were reminded that the disposal of medicines record should be signed by the registered nurse responsible and a designated witness. This process was not evidenced consistently in records.

Medicines were mostly stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and organised. Medicine refrigerators and oxygen equipment were checked at regular intervals. However, the systems in place to manage medicines with a limited shelf life once opened were not satisfactory. Most eye preparations and insulin pen devices expire 28 days after opening. All of the eye preparations in use had passed their expiry date after opening or were not marked with the date of opening and therefore the expiry date could not be determined. Insulin pen devices that were in use had not been marked with the date of opening. A robust system must be put into place so that medicines with a limited shelf life after opening are not administered once the expiry date is reached. A requirement was made.

**Areas for improvement**

A robust system must be put into place so that medicines with a limited shelf life after opening are not administered once the expiry date is reached. A requirement was made.

| **Number of requirements** | 1 | **Number of recommendations** | 0 |
|---|---|---|---|

## 4.4 Is care effective?

Most of the medicines examined had been administered in accordance with the prescriber's instructions. A small number of medicines did not state the date of opening and the audit trails could not be concluded. The date of opening should be recorded on all medicines to facilitate audit. A recommendation was made.

The method of measuring liquid medicines was observed. The appropriate measuring syringes were not always used; insulin syringes and syringes intended for blood samples were sometimes used. The measuring of liquid medicines should be reviewed to ensure that an appropriate oral syringe is used. A recommendation was made.

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, 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 reason for and the outcome of administration were not always recorded. A care plan was not maintained in the sample of records examined.

The management of these medicines should be reviewed to ensure that all of the appropriate records are maintained. 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 pain was well controlled and the patient was comfortable. The registered manager advised that most of the patients could verbalise any pain and that staff can otherwise recognise patient specific behaviour which would indicate that they were in pain. However, a care plan for the management of pain was not in place for all relevant patients. A recommendation was made.

The management of swallowing difficulty was examined. For three of the four records examined, this was recorded on the personal medication record and included details of the fluid consistency. Care plans and speech and language assessment reports were in place. For one patient, concerns raised by a registered nurse on duty regarding their ability to swallow medicines and nutritional supplements due to a swallowing difficulty were discussed. These concerns had been raised with the prescriber. Staff were referred to the instructions recorded in the speech and language assessment report and were advised to seek further advice from the relevant healthcare professionals as necessary.

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 generally well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the use of transdermal analgesia patch application records and the use of protocols for medicines prescribed on a "when required" basis.

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

**Areas for improvement**

The date of opening should be recorded on all medicines to facilitate audit. A recommendation was made.

The measuring of liquid medicines should be reviewed to ensure that an appropriate oral syringe is used. A recommendation was made.

The management of medicines prescribed on a "when required" basis for the management of distressed reactions should be reviewed to ensure that all of the appropriate records are maintained. A recommendation was made.

A care plan for the management of pain should be maintained for all relevant patients. A recommendation was made.

| **Number of requirements** | 0 | **Number of recommendations** | 4 |
|---|---|---|---|

## 4.5 Is care compassionate?

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

The patients spoken to advised that they were satisfied with the manner in which their medicines were managed and administered. They were complementary about the staff and their care in the home.

Relationships between staff and patients and visitors were observed to be warm and friendly. The home was busy with visitors and some were observed bringing family pets to visit their relatives.

**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.

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.

Practices for the management of medicines were audited throughout the month by the staff and management. In addition, a quarterly audit was completed by the community pharmacist. Records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was usually evidence of the action taken, escalation to management and any learning which had resulted in a change of practice. The registered manager was advised to review the audit system to ensure it includes the areas for improvement highlighted.

Following discussion with the registered manager and the 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 to staff individually and at team meetings.

**Areas for improvement**

No areas for improvement were identified during the inspection.

| Number of requirements | 0 | Number of recommendations | 0 |
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## 5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Jean Steele, 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 through the 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

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| **Statutory requirements** | |
| **Requirement 1**<br><br>**Ref**: Regulation 13(4)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>5 November 2016 | The registered provider must ensure that a robust system is in place so that medicines with a limited shelf life after opening are not administered once the expiry date is reached. |
| | **Response by registered provider detailing the actions taken:**<br>all trained staff made aware that medicines with a limited shelf life are not administered once expiry date is reached. Management of expiry dates will be monitored via the monthly and daily medication audit. |
| **Recommendations** | |
| **Recommendation 1**<br><br>**Ref**: Standard 30<br><br>**Stated:** First time<br><br>**To be completed by:**<br>5 November 2016 | The registered provider should ensure that the date of opening is recorded on all medicines to facilitate audit. |
| | **Response by registered provider detailing the actions taken:**<br>Trained staff informed that date of opening must be recorded on all medications. Date of openings wll be monitored via the monthly and daily medication audit. |
| **Recommendation 2**<br><br>**Ref**: Standard 30<br><br>**Stated:** First time<br><br>**To be completed by:**<br>5 November 2016 | The registered provider should ensure that the measuring of liquid medicines is reviewed to ensure that an appropriate oral syringe is used. |
| | **Response by registered provider detailing the actions taken:**<br>The appropriate oral syringes have been obtained from pharmacy and are in use. |
| **Recommendation 3**<br><br>**Ref**: Standard 18<br><br>**Stated:** First time<br><br>**To be completed by:**<br>5 November 2016 | The registered provider should ensure that the management of medicines prescribed on a “when required” basis for the management of distressed reactions is reviewed to ensure that all of the appropriate records are maintained. |
| | **Response by registered provider detailing the actions taken:**<br>Staff to ensure that medication given is recorded in progress notes,care plans,and drug recording sheets, effectiveness and side effects to be recorded as well |
| **Recommendation 4**<br><br>**Ref**: Standard 4<br><br>**Stated:** First time<br><br>**To be completed by:**<br>5 November 2016 | The registered provider should ensure that a care plan for the management of pain is maintained for all relevant patients. |
| | **Response by registered provider detailing the actions taken:**<br>Care plans for the management of pain are being maintained |

***Please ensure this document is completed in full and returned through the web portal***

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