Unannounced Medicines Management Inspection Report
6 December 2016

Broadways Private Nursing Home

Type of Service: Nursing Home
Address: Broadway, Main Street, Larne, BT40 1LT
Tel no: 028 2827 3464
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Broadways Private Nursing Home took place on 6 December 2016 from 10.45 to 14.15.

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.

Is care safe?

There was mostly satisfactory 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 mostly satisfactory systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. However, several areas for improvement were identified in relation to the maintenance of personal medication records, the management of records and the disposal of controlled drugs. One requirement and four recommendations were made. One of the recommendations was stated for a second time.

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 for improvement was identified in relation to the record of the disposal of medicines.

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. No requirements or recommendations were made.

Is the service well led?

The service was found to be largely well led with respect to the management of medicines; however areas for improvement were identified within two of the other domains. 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. No requirements or recommendations were 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	1	5

Details of the Quality Improvement Plan (QIP) within this report were discussed with the registered nurse in charge, Ms Michelle McIlwaine, 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 22 November 2016.

2.0 Service details

Registered organisation/registered person: Mrs Barbara Sloan	**Registered manager:** Mrs Jacqueline Davey
Person in charge of the home at the time of inspection: Ms Michelle McIlwaine, Registered Nurse	**Date manager registered:** 7 March 2012
Categories of care: NH-PH, NH-I	**Number of registered places:** 33

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- medicine incidents - it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with two patients and two registered nurses.

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.

Twenty-five questionnaires were issued to patients, patients' relatives/representatives and staff, with a request that these were completed and returned to RQIA within one week of the inspection.

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 22 November 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 25 June 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	It is recommended that the date of opening is recorded on insulin pen devices to facilitate audit and prevent their use after expiry.	**Not Met**
	Action taken as confirmed during the inspection: The date of opening was not recorded on the two insulin pen devices in use. This recommendation was stated for a second time.	
Recommendation 2 **Ref**: Standard 18 **Stated:** First time	It is recommended that the management of medicines prescribed on a "when required" basis for the management of distressed reactions is reviewed to ensure that a care plan is in place and that the reason for administration and the outcome are recorded on each occasion.	**Met**
	Action taken as confirmed during the inspection: Of the records examined, a care plan was in place and on most occasions the reason for and the outcome of administration had been recorded. It was acknowledged that a specific record had been developed and implemented for these medicines.	

4.3 Is care safe?

Medicines were managed by staff that had 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.

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.

The arrangements in place to manage changes to prescribed medicines were examined. Printed medicine administration records had been introduced. Personal medication records were no longer kept alongside medicine administration records and were not used within the medicines administration process. As a result, personal medication records were not up to date, did not always include the patient's allergy status and were not always verified by a second member of staff to ensure accuracy in transcription. A requirement was made. It was recommended that handwritten entries on printed medicine administration records should be signed and should be verified by a second competent member of staff to ensure accuracy in transcription.

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.

The arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged. Procedures were largely satisfactory; however the date of opening was not recorded on the insulin pen devices in use. A recommendation made at the last inspection was stated for a second time. The insulin pen devices in use were refrigerated. It was agreed that these would be stored at room temperature, according to the manufacturer's instructions. This was addressed immediately.

In relation to warfarin, staff advised that written instructions of updates to warfarin regimes were not always received promptly and that one registered nurse takes verbal instructions via a telephone call. It was recommended that, in accordance with the home's policy and procedures, a second competent member of staff is involved and that both members of staff transcribe these instructions and sign the record to verify their accuracy. A recommendation was made.

The disposal of discontinued or expired medicines was examined. Medicines were mostly disposed of appropriately (see section 4.4). Discontinued controlled drugs in Schedules 2 and 3 were denatured and rendered irretrievable prior to disposal. However, procedures should be reviewed to ensure that this also takes place for controlled drugs in Schedule 4 (Part 1). A recommendation was made.

Medicines were 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.

Areas for improvement

Personal medication records must be accurately maintained at all times. A requirement was made.

The date of opening should be recorded on insulin pen devices to facilitate audit and prevent their use after expiry. A recommendation was stated for the second time.

Handwritten entries on printed medicine administration records should be signed and should be verified by a second competent member of staff to ensure accuracy in transcription. A recommendation was made.

A second competent member of staff should be involved in receiving telephoned warfarin dosage instructions and should sign the record of transcribed dosages to verify accuracy. A recommendation was made.

Procedures for the disposal of controlled drugs should be reviewed to ensure that controlled drugs in Schedule 4 (Part 1) are denatured and rendered irretrievable prior to disposal. A recommendation was made.

Number of requirements	1	**Number of recommendations**	4

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, 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 recorded in most of the records examined. Staff were advised to record the outcome on every occasion. A care plan was maintained.

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. 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 and included details of the fluid consistency. 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 largely well maintained and facilitated the audit process. Areas of good practice were acknowledged. These included running stock balances for analgesics and anxiolytics prescribed for use 'when required'. A second competent member of staff should verify and sign the record of disposal of medicines. A recommendation was made.

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. Staff were advised that carrying forward the balance of remaining stock on the medicines administration record sheet would further facilitate audit, for all medicines not supplied in the monitored dosage system.

Following discussion with the registered manager and staff and a review of the care files, it was evident that when applicable, other healthcare professionals are contacted in response to concerns about medicines management.

Areas for improvement

A second competent member of staff should verify and sign the record of the disposal of medicines. A recommendation was made.

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

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.

The patients spoken to were complimentary about their care in the home and about the staff.

As part of the inspection process, questionnaires were issued to patients, relatives/patients' representatives and staff. Three members of staff, three patients and two relatives completed and returned these within the specified timescale. All of the responses were recorded as 'very satisfied' with the medicines management in the home.

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.

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

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.

Following discussion with the registered nurses on duty, 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.

Not all of the recommendations made at the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement 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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with the registered nurse in charge, Ms Michelle McIlwaine, 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	
Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 6 January 2017	The registered provider must ensure that personal medication records are accurately maintained at all times.
	Response by registered provider detailing the actions taken: A new more robust system of recording and checking personal medication records has been implemented. At least once monthly audits will ensure accurate records are maintained.
Recommendations	
Recommendation 1 **Ref**: Standard 30 **Stated:** Second time **To be completed by:** 6 January 2017	It is recommended that the date of opening is recorded on insulin pen devices to facilitate audit and prevent their use after expiry.
	Response by registered provider detailing the actions taken: All nurses have been issued a nursing memo reminding them that this has to be done. A notice has been displayed on both the fridge and administration tray for an added reminder.
Recommendation 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 6 January 2017	The registered provider should ensure that handwritten entries on printed medicine administration records are signed and are verified by a second competent member of staff to ensure accuracy in transcription.
	Response by registered provider detailing the actions taken: Nurses have been reminded by nursing memo that two signatures are required on al handwritten entries. This will be audited at least monthly.

Recommendation 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 6 January 2017	The registered provider should ensure that a second competent member of staff is involved in receiving telephoned warfarin dosage instructions and signs the record of transcribed dosages to verify their accuracy.
	Response by registered provider detailing the actions taken: Staff notified that two staff to be involved in telephone warfarin instructions. Also, to ensure surgeries follow up telephone conversation with a fax. Two staff to sign received fax.
Recommendation 4 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 6 January 2017	The registered provider should ensure that procedures for the disposal of controlled drugs are reviewed to ensure that controlled drugs in Schedule 4 (Part1) are denatured and rendered irretrievable prior to disposal.
	Response by registered provider detailing the actions taken: All drugs on Schedule 4 (part 1) will denatured and rendered irretrievable prior to disposal. Staff aware of same. I have spoken to our Pharmacy as we were advised about dispisal of drugs by Pharmacist.
Recommendation 5 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 6 January 2017	The registered provider should ensure that a second competent member of staff verifies and signs the record of the disposal of medicines.
	Response by registered provider detailing the actions taken: Staff have been informed that two staff must verify and sign the disposal of medicines. This will be audited at least monthly.

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

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