Unannounced Medicines Management Inspection Report
14 February 2017

Abbeylands

Type of Service: Nursing Home
Address: 441 Shore Road, Whiteabbey, Belfast, BT37 9SE
Tel no: 028 9086 4552
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Abbeylands took place on 14 February 2017 from 10.10 to 15.30.

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. However, one area for improvement in relation to the management of warfarin was identified. A recommendation was made.

Is care effective?

Most areas for the management of medicines supported the delivery of effective care. Four areas for improvement in relation to the management of distressed reactions, antibiotics, recording dates of opening and records of disposal were identified. Four recommendations were made. One of these recommendations was stated for the third and final time.

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 for 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. One area for improvement in relation to the home's auditing system was identified 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 and 5.0 of this report.

For the purposes of this report, the term 'patients' will be used to described those living in Abbeylands which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	6

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Eleanor Dodson, 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 premises inspection

There were no further actions required to be taken following the most recent inspection on 9 December 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Ms Eleanor Dodson
Person in charge of the home at the time of inspection: Ms Eleanor Dodson	**Date manager registered:** 19 November 2014
Categories of care: RC-A, RC-MP, RC-I, RC-MP(E), RC-PH(E), NH-I, NH-PH, NH-PH(E)	**Number of registered places:** 87

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 three patients, one senior care assistant, two registered nurses, the deputy manager 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.

Fifteen questionnaires were issued to patients, relatives/patients' representatives and staff, with a request that they were returned within one week from the date 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 9 December 2016

The most recent inspection of the home was an announced variation application premises inspection. No requirements or recommendations were made.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 14 January 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must closely monitor the management of refrigerator temperatures and ensure that all medicines which require cold storage are stored at the temperature specified by the manufacturer.	**Met**
	Action taken as confirmed during the inspection: The recordings for the refrigerator temperatures indicated that temperatures outside the recommended range were frequently being recorded. This had been recognised as unsatisfactory by the registered nurses. At the beginning of the inspection the registered manager advised that this was being followed up and new refrigerators were on order. The thermometers were reset during the inspection and satisfactory readings were observed indicating that the issue was due to incorrect use of the thermometers rather that the refrigerators. We provided guidance on using the thermometers to four members of staff during the inspection. Due to the action already taken and the assurances provided by the registered manager, this requirement was assessed as met and was not restated.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 38 **Stated:** Second time	Two nurses should sign entries in the record of medicines disposed of.	**Not Met**
	Action taken as confirmed during the inspection: A review of the records of disposal indicated that two registered nurses do not sign the entries. The QIPs returned after the two previous medicines management inspections advised that this recommendation had been addressed. This inspection again evidenced that any compliance had not been sustained. Following discussion with senior management in RQIA this recommendation was stated for the third and final 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 for care staff who had been delegated medicine related tasks. Competency assessments were completed annually. The impact of training was monitored through team meetings, supervision and annual appraisal. Refresher training in the management of thickening agents was being provided for staff by the registered manager.

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 or two senior care assistants.

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.

Robust arrangements were observed for the management of insulin.

The management of warfarin was reviewed. Dosage directions were received in writing and transcribing involved two members of staff. A separate administration chart was maintained; improvements in the layout of this recording sheet to assist in the timely identification of errors

were suggested. Obsolete warfarin dosage directions had not been cancelled and archived. A recommendation was made.

Appropriate arrangements were in place for administering medicines in disguised form.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Medicines were stored safely and securely. 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. However as detailed in Section 4.2 temperatures outside the accepted range were recorded for both refrigerators. Staff had referred this to the community pharmacy.

Areas for improvement

The registered provider should review and revise the management of warfarin. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

The majority of medicines examined had been administered in accordance with the prescriber's instructions. The registered manager and staff agreed to closely monitor the administration of inhaled medicines and eye preparations. Some audits could not be completed as dates of opening had not been recorded. A recommendation was made.

The management of antibiotic medicines was reviewed for two patients. For one patient administration did not commence until the day after the antibiotic had been prescribed and dispensed. For the second patient the course was completed a day late indicating that the dosage regimen had not been adhered to. These findings had not been identified through the home's running stock balances. 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.

The management of medicines which were prescribed to be administered "when required" for the management of distressed reactions was reviewed for two patients. The dosage instructions were recorded on the personal medication record. A care plan was in place for one patient only. 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 was being recorded for one of the patients. For the second patient the medicine was being administered most nights; this had not been referred to the prescriber for review. The management of these medicines should be reviewed and revised. A recommendation was made.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were being maintained. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff advised that a pain assessment tool was being used with

patients who could not verbalise their pain. Staff also advised that a pain assessment is 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. Care plans and speech and language assessment reports were in place. Administration was being recorded.

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 the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. However, records of disposal were still not being signed by two trained members of staff (see Section 4.2). A recommendation was stated for the third and final time.

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.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas for improvement

Two nurses should sign entries in the record of medicines disposed of. A recommendation was stated for the third and final time.

The registered provider should ensure that dates of opening are recorded on all medicine containers. A recommendation was made.

The registered provider should closely monitor the management of antibiotics to ensure that courses are commenced promptly and dosage regimens are adhered to. A recommendation was made.

The registered provider should review the management of "when required" medicines for the management of distressed reactions to ensure that detailed care plans are in place, the reason for and outcome of administration are recorded and regular use is referred to the prescriber for review. A recommendation was made.

Number of requirements	0	Number of recommendations	4

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.

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.

We spoke with three patients who advised that they were happy with the care provided by the staff.

As part of the inspection process 15 questionnaires were issued to patients, relatives/representatives and staff, with a request that they were returned within one week from the date of the inspection. Two relatives completed and returned the questionnaires. The responses were positive and these were recorded as "very satisfied" with regard to the management of medicines 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. 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 home's audit records indicated that satisfactory outcomes had been achieved. This inspection identified a number of areas for improvement and one recommendation was stated for the third and final time. It was therefore recommended that the auditing system should be reviewed and revised to ensure that it identifies and addresses medicine related issues. A recommendation was made. To ensure that all requirements and recommendations are fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement 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 any resultant action was communicated with all staff either individually or via team meetings.

Areas for improvement

The registered provider should ensure that a robust audit tool is used to identify and address medication related issues. A recommendation was made.

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 Ms Eleanor Dodson, 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 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 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

Recommendations	
Recommendation 1 **Ref:** Standard 38 **Stated:** Third and final time **To be completed by:** 16 March 2017	Two nurses should sign entries in the record of medicines disposed of. **Response by registered provider detailing the actions taken:** Home manager or Deputy are now auditing the drugs returns books every Monday morning. All nursing staff have been informed that they must meet this recommendation by ensuring that the drugs return book is countersigned.
Recommendation 2 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 16 March 2017	The registered provider should review and revise the management of warfarin. **Response by registered provider detailing the actions taken:** A weekly audit of all Warfarin administration is conducted on a weekly basis by either the home manager, deputy or nursier sister.
Recommendation 3 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 16 March 2017	The registered provider should ensure that dates of opening are recorded on all medicine containers. **Response by registered provider detailing the actions taken:** Supervisions with nursing staff have been completed on the subject.
Recommendation 4 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 16 March 2017	The registered provider should closely monitor the management of antibiotics to ensure that courses are commenced promptly and dosage regimens are adhered to. **Response by registered provider detailing the actions taken:** The home manager or the deputy now audit all prescribed antibiotics to ensure the administration regime is adhered to.

Recommendation 5 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 16 March 2017	The registered provider should review the management of "when required" medicines for the management of distressed reactions to ensure that detailed care plans are in place, the reason for and outcome of administration are recorded and regular use is referred to the prescriber for review.
	Response by registered provider detailing the actions taken: A review of all PRN medications for distressed reactions has been completed and care plans have been put in place.
Recommendation 6 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 16 March 2017	The registered provider should ensure that a robust audit tool is used to identify and address medication related issues.
	Response by registered provider detailing the actions taken: The home manager has a monthly medication audit that is completed, there is also daily and weekly medication audits completed via the QOL I-PAD.

Please ensure this document is completed in full and returned via web portal

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