Unannounced Medicines Management Inspection Report
1 July 2016

Galgorm

Type of Service: Nursing Home
Address: 90 Galgorm Road, Ballymena, BT42 1AA
Tel No: 028 2565 1365
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Galgorm took place on 1 July 2016 from 10.10 to14.10.

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. Staff were trained and competent and there were robust processes for the stock control of medicines, management of medicines changes and management of high risk medicines. No requirements or recommendations have been made.

Is care effective?

There was evidence that the management of medicines supported the delivery of effective care and positive outcomes for patients. There were systems in place to ensure that the patients were administered their medicines as prescribed. Robust arrangements were in place for the management of pain, distressed reactions and dysphagia. One recommendation in relation to inhaled medicines has been made. No requirements have been made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Patients spoke positively about their care in the home and the management of their medicines. Staff interactions with patients were observed to be compassionate, caring and timely. No requirements or recommendations have been made.

Is the service well led?

There was evidence that the service was well led with respect to the management of medicines. Written medicine policies and procedures were in place. Robust systems for the management of medicine related incidents and the auditing of medicines management were observed. 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.

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.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with the nurse in charge, Ms Glenda Gabreza at the inspection and with the covering manager, Mrs Wendy McMaster by telephone after the inspection, 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

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 provider: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Mrs Lisa McDonald
Person in charge of the home at the time of inspection: Ms Glenda Gabreza	**Date manager registered:** 16 January 2015
Categories of care: RC-I, RC-PH, RC-PH(E), NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 35

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 care staff, and the registered nurse in charge.

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. No one availed of the opportunity.

The following records were 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. No requirements or recommendations were made following this inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 14 October 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** Second time	The maintenance of medicine administration records must be reviewed to ensure that: • records of the administration of external preparations are fully completed.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area of medicines management had been reviewed and was included in the registered manager's audit process. The outcome of the registered manager's audit was displayed in the treatment room for all staff to read and sign. There was evidence that the external preparations had been administered as prescribed. The completion of administration records was also checked by registered nurses during the month.	
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person must investigate the observations made in Patient A's anti-emetic medicine; a written report of the findings and action taken must be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: The written report regarding the investigation and follow up action was received by RQIA on 15 October 2014.	
Requirement 3 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person must make the necessary arrangements to ensure that personal medication records are kept fully and accurately maintained at all times.	**Met**
	Action taken as confirmed during the inspection: An improvement in the standard of maintenance of personal medication records was evidenced at the inspection.	

Requirement 4 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person must put robust arrangements in place for the management of controlled drugs as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The management of controlled drugs had been reviewed. Staff confirmed that the records were signed at the time of administration and two staff were involved in the administration.	
Requirement 5 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person must put robust arrangements in place for the management of medicines which require cold storage.	**Met**
	Action taken as confirmed during the inspection: Satisfactory arrangements were in place for the cold storage of medicines.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 37 **Stated:** Second time	All handwritten updates on medicine records should involve two members of staff.	**Met**
	Action taken as confirmed during the inspection: On the sample of records examined, there was evidence that two staff had initialled handwritten updates on the medication administration records. This was not always recorded on the personal medication records and was discussed with the staff, who stated that this was the expected practice. It was agreed that this would be raised with all registered nurses and a reminder notice put in place.	
Recommendation 2 **Ref:** Standard 37 **Stated:** First time	The registered person should review the disposal of medicines process to ensure that two members of staff are involved in the disposal of each medicine.	**Met**
	Action taken as confirmed during the inspection: A review of the disposal of medicine record books indicated that two members of staff were involved in the disposal of medicines.	

Recommendation 3 **Ref:** Standard 38 **Stated:** First time	The registered person should ensure that personal medication records and medication administration records are checked for accuracy at the beginning of each new medicine cycle.	**Met**
	Action taken as confirmed during the inspection: Staff confirmed that this practice occurs each month.	
Recommendation 4 **Ref:** Standard 38 **Stated:** First time	The registered person should review the management of distressed reactions to ensure the relevant records are being maintained.	**Met**
	Action taken as confirmed during the inspection: The management of distressed reactions had been reviewed. Training had been provided and care plans were maintained. The administration of medicines was documented in the medicine records and daily notes.	
Recommendation 5 **Ref:** Standard 38 **Stated:** First time	The registered persons should ensure that the prescribed consistency of thickened fluids is recorded on personal medication records and administration records.	**Met**
	Action taken as confirmed during the inspection: The sample of personal medication records and administration records indicated that the prescribed consistency level of thickened fluids was recorded.	

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. Training was provided through attendance at training sessions and the completion of e-learning modules. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training was provided in the last year. The most recent training was in relation to the management of distressed reactions.

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 largely satisfactory arrangements in place to manage changes to prescribed medicines. Handwritten entries on medication administration records were updated by two registered nurses to ensure the transcribing was accurate. This also occurred when writing new personal medication records; however, some medicine changes had not been verified by a second member of staff, which was the expected practice. This was discussed and it was agreed that this would be addressed with the registered nurses.

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.

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

Discontinued or expired medicines were disposed of appropriately. Staff confirmed that discontinued controlled drugs were denatured and rendered irretrievable prior to disposal and a separate disposal book for controlled drugs was maintained. It was noted that some Schedule 4 controlled drugs such as zolpidem and zopiclone had not been denatured prior to disposal. Staff were unaware that these medicines were required to be denatured. It was agreed that this practice would be implemented from the day of the inspection onwards and discussed with all registered nurses.

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?

With the exception of two inhaled medicines the sample of medicines examined had been administered in accordance with the prescriber's instructions. The discrepancies noted in the audit trails performed on inhaled medicines were discussed and close monitoring was recommended. It was agreed that this finding would be reported to the patients' prescriber.

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. These medicines were rarely administered. A care plan was maintained and there was evidence that the reason for and the outcome of administration were 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 most of the patients could verbalise any pain, and a pain assessment tool was used as needed. 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. 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. Areas of good practice were acknowledged. They included separate administration records for transdermal patches and daily checks to ensure these medicines remained in place on the patient. It was noted that a small number of personal medication records should be rewritten to ensure clarity and staff confirmed that this would be addressed.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for most medicines which were not included in the 28 day blister packs. This good practice was acknowledged. In addition, a quarterly audit was completed by the community pharmacist. In view of the findings regarding inhaled medicines, the audit procedures for these medicines should be reviewed.

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

Areas for improvement

The audit process should be reviewed to ensure that inhaled medicines are closely monitored and are administered as prescribed. 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 at the inspection stated that they were content with their care in the home and had no concerns regarding the management of their medicines. They advised that staff responded in a timely manner to any requests for medicines e.g. pain relief. They spoke positively about the staff and comments included:

- "Very good staff here."
- "I always have company."
- "I like it here and where I sit."

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. These were discussed with staff, who advised that they were advised of any updates.

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 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 nurse and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

It was noted that the staff were very knowledgeable regarding the individual patient needs with respect to medicines.

Staff advised that management were open and approachable and willing to listen. They spoke positively about their work and stated that there were good working relationships within the home.

The requirements and recommendations made at the last medicines management inspection had been addressed.

Staff confirmed that any concerns in relation to medicines management were raised with the registered manager and registered nurses. They advised that any resultant action was communicated through team meetings and at handover.

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 this QIP were discussed with Ms Glenda Gabreza, Nurse in Charge and Mrs Wendy McMaster, Covering 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 the 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:** 1 August 2016	The registered provider should closely monitor the administration of inhaled medicines to ensure that these are administered as prescribed.
	Response by registered provider detailing the actions taken: All registered nurses must now record the date of opening and the date the inhaler should finish. Registered nurses must record that 2 puffs were given. I can confirm that I will spot check inhaled medicines as part of the Home Managers monthly audit.

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

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