Unannounced Medicines Management Inspection Report
2 May 2017

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 2 May 2017 from 10.00 to 14.00.

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 largely satisfactory systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. One area for improvement was identified in relation to medicine changes. One recommendation was made.

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. Care plans relating to areas of medicines management were in place. No requirements or 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. The patient 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 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. 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.

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 Mrs Lisa McDonald, 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 dated 15 December 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/ Dr Maureen Claire Royston	**Registered manager:** Mrs Lisa McDonald
Person in charge of the home at the time of inspection: Mrs Lisa McDonald	**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 one patient, one member of care staff, 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 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

Fifteen questionnaires were issued to patients, their relatives/representatives and staff, with a request that these were completed and returned within one week of the inspection.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 15 December 2016

The most recent inspection of the home was an announced premises inspection. There were no issues identified during this inspection, and no requirements or recommendations were made.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 1 July 2016

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 28 **Stated:** First time	The registered provider should closely monitor the administration of inhaled medicines to ensure that these are administered as prescribed.	**Met**
	Response by registered provider detailing the actions taken: There was evidence that these medicines were regularly monitored. This was facilitated by a permanent record of the start date and expected end of date for inhaled medicines.	

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, agency 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 at least every two years.

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 management of prescription forms was discussed. It was agreed that these would be kept in a locked cupboard from the day of the inspection onwards.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. Antibiotics and new medicines had been received and commenced in a timely manner. On occasion, the handwritten medicine updates on personal medication records and medication administration records were signed and verified by two registered nurses. This should occur on every occasion to ensure safe practice; one recommendation was made.

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.

Robust arrangements were observed for the management of high risk medicines.

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. Staff were advised that due to the variety of brands of buprenorphine patch, the medicine name should be documented in the record book, instead of the brand name.

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 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. The good practice of recording the expected expiry date of these medicines was acknowledged. Medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas for improvement

The necessary arrangements should be made to ensure that the transcribing of medicines information onto personal medication records and medication administration records involves two members of trained staff. A recommendation was made.

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

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.

Satisfactory arrangements were in place for the management of pain, swallowing difficulty and distressed reactions.

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. They provided details of the management of two patients' medicines, regarding ongoing refusal and swallowing difficulty.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for high risk medicines and transdermal patches. In addition, protocols for the administration of medicines prescribed on a 'when required' basis were also maintained, e.g. anxiolytics, analgesics and inhaled medicines.

Following discussion with the registered manager and staff and review of a sample of patients' care files, it was evident that when applicable, other healthcare professionals were contacted in response to patients' healthcare needs.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

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.

Throughout the inspection, it was found that there were good relationships between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity. It was clear that the staff were familiar with the patients' needs, their likes and dislikes.

The patient spoken to had no concerns regarding the management of their medicines and advised that staff responded in a timely manner to any requests for pain relief or care.

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.

As part of the inspection, questionnaires were issued to patients, their relatives/representatives and staff. Six questionnaires were completed and returned. The responses were recorded as 'very satisfied' or 'satisfied' with 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. Management advised that some of these had been recently updated. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

In relation to the regional safeguarding procedures, staff confirmed they were familiar with these and were aware of when incidents must be considered as reportable to the adult safeguarding lead. Training had been provided and further training was planned. A safeguarding file was in place and included a policy, details of the names and contact numbers for the safeguarding lead and the safeguarding team. A specific flowchart was in place to report incidents.

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.

Medicines management was audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines, nutritional supplements and inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist. Where areas for improvement had been identified, these were shared with staff in writing, to read and address.

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 advised that management were open and approachable and willing to listen. They stated that there were good working relationships within the home and with healthcare professionals involved in patient care. They confirmed that any concerns in relation to medicines management were raised with management.

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 Mrs Lisa McDonald, 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 RQIA 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 29 **Stated:** First time **To be completed by:** 2 June 2017	The registered provider should ensure that two trained staff are involved in transcribing medicines information onto personal medication records and medication administration records; both staff should initial the entry. **Response by registered provider detailing the actions taken:** Registered nurses have received clinical supervision on ensuring two trained staff are involved in transcribing medication entries on both the medication administration records and the MARS sheets. The home manager will check this through the mediaction audit process .

Please ensure this document is completed in full and returned to RQIA 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