Unannounced Medicines Management Inspection Report
10 May 2018

Whiteabbey

Type of Service: Nursing Home
Address: 104-106 Doagh Road, Newtownabbey, BT37 9QP
Tel no: 028 9085 3021
Inspector: Helen Daly

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 59 beds that provides care for patients with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** Mrs Aleyamma George
Person in charge at the time of inspection: Mrs Aleyamma George	**Date manager registered:** 20 May 2011
Categories of care: Nursing Homes (NH) I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years	**Number of registered places:** 59 including: a maximum of one named resident receiving residential care in category RC-I The home is also approved to provide care on a day basis only to one person.

4.0 Inspection summary

An unannounced inspection took place on 10 May 2018 from 10.00 to 13.45.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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.

The inspection assessed progress with any areas for improvement identified since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staff training, medicines administration, medicine records and the auditing systems.

One area for improvement was identified in relation to the standard of maintenance of the medication administration records.

Patients were complimentary about the staff and the care provided in the home.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Aleyamma George, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 23 January 2018. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

- 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.

During the inspection we met with two patients, two care assistants, two registered nurses and the registered manager.

Ten questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

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
- medicine audits
- policies and procedures
- medicines storage temperatures

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 23 January 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 6 February 2017

There were no areas for improvement identified as a result of the last medicines management inspection.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager advised that medicines were managed by registered nurses who have been trained and deemed competent to do so. Training had been provided by the community pharmacist within the last year. Training was also updated annually via e-learning. 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 the internal auditing systems, team meetings, supervision and annual appraisal. Competency assessments were completed annually or more often if a need was identified.

The registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and to manage changes to prescribed medicines. Personal medication records were verified and signed by two registered nurses. This safe practice was acknowledged. However, the majority of hand-written updates on the medication administration records had not been verified and signed by two registered nurses. An area for improvement with regards to the maintenance of medication administration records was identified in Section 6.5.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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.

Mostly satisfactory arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged. The registered manager was reminded that obsolete dosage directions for warfarin should be cancelled and archived and that the abbreviation 'i.u.' should not be used for insulin. Due to the assurances provided an area for improvement was not identified.

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. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. However, one liquid antibiotic was observed to be in use after its expiry date. It was replaced during the inspection and systems were put in place to ensure that all registered nurses would be made aware of the limited shelf-life after reconstitution. Medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and controlled drugs.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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, biweekly or three monthly medicines were due.

The management of distressed reactions, pain and thickening agents was reviewed and found to be satisfactory. Care plans and records of prescribing and administration were maintained.

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. The registered manager was reminded that obsolete personal medication records should be cancelled and archived and that when more than one personal medication record is in use this should be highlighted e.g. '1 of 2'. Registered nurses had continued to sign for the administration of one medicine for ten days after it had been discontinued. The medicine had not been administered. As stated in Section 6.4, hand-written updates on the medication administration records should be verified and signed by two registered nurses. Systems should be reviewed to ensure that medication administration records are accurately maintained. An area for improvement was identified.

Practices for the management of medicines were audited throughout the month by the staff and management. The medicines for three patients were audited on each floor each day.

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 of good practice

There were examples of good practice in relation to the standard of record keeping, the auditing systems and the administration of medicines.

Areas for improvement

Systems should be reviewed to ensure that medication administration records are accurately maintained.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We observed the administration of medicines to a small number of patients. The administration was completed in a caring manner and patients were given time to take their medicines. Staff were knowledgeable about the administration of medicines and guidance was displayed on the medicines file for easy reference.

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 from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes.

Patients were observed to be relaxed and comfortable. The patients spoken to at the inspection were complimentary about the staff and care provided in the home.

As part of the inspection process, we issued ten questionnaires to patients and their representatives. Seven were completed and returned. The responses indicated that they patients and relatives were satisfied/ very satisfied with all aspects of the care in relation to the management of medicines.

Areas of good practice

Observation of the care practices evidenced that staff adopted a person centred care approach, staff were observed to communicate with patients in a manner that was sensitive and understanding of their needs.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The inspector discussed arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. The registered manager advised that arrangements were in place to implement the collection of equality data within Whiteabbey.

Written policies and procedures for the management of medicines were available in the treatment rooms. These were not examined in detail.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

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 manager, registered nurses and care assistants, 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 were complimentary regarding the management of the home and advised that training and support was 'excellent'.

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Aleyamma George, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 10 June 2018	The registered person shall ensure that the necessary improvements are made in relation to medication administration records. Ref: 6.4 and 6.5
	Response by registered person detailing the actions taken: The personal medication records / obsolete records have been removed and archived. RNs have documented /written the number of the Kardex as 1 of 2 where there is more than 1 Kardex/ personal medication record for service user - where applicable. Any updated/hand written medication administration record is checked and verified by x2 RNs. The RNs are made aware of the area for improvement for compliance.

Please ensure this document is completed in full and returned via the Web Portal

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