Unannounced Medicines Management Inspection Report
4 August 2016

Glenview

Type of Service: Nursing Home
Address: 11 Bleary Road, Portadown, Craigavon, BT63 5NE
Tel No: 02838350500
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Glenview took place on 4 August 2016 from 09:30 to 13:30.

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 mostly 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 of improvement was identified in relation to the management of warfarin; a requirement 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. One area of improvement was identified in relation to the documentation of the route of administration of eye medicines on the medicine records; a recommendation was 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. Patients consulted with confirmed that they were administered their medicines appropriately. There were no areas of 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 and medicine audit activity. There were no areas of improvement identified.

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.

1.1 Inspection outcome

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Debra Ann Hawthorne, Acting 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 estates inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 28 July 2016.

2.0 Service details

Registered organisation/registered person: Glenview/ Mrs Bernadette Breen Mr Brendan Breen	**Registered manager:** See box below
Person in charge of the home at the time of inspection: Ms Debra Ann Hawthorne (Acting Manager)	**Date manager registered:** Ms Debra Ann Hawthorne – application not yet submitted
Categories of care: NH-PH(E), NH-PH, NH-I, NH-DE	**Number of registered places:** 31

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, the acting manager and one registered nurse.

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.

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 28 July 2016

The most recent inspection of the home was an announced estates inspection. The completed QIP will be reviewed by the estates inspector whenever it is returned to RQIA. This QIP will be validated by the estates inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 21 September 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	It is recommended that the registered manager should ensure all discontinued or expired medicines awaiting uplift for disposal are securely stored.	**Met**
	Action taken as confirmed during the inspection: Discontinued or expired medicines awaiting uplift for disposal were securely stored.	

4.3 Is care safe?

Medicines were managed by staff who 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. Refresher training in medicines management was provided to the nursing staff by the community pharmacist in April 2016.

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 and handwritten entries on medicine administration records were updated by two registered nurses. This safe practice was acknowledged.

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.

Some improvement was needed in the management of warfarin. One patient had recently been administered an incorrect dose and, for another patient, one warfarin 3mg tablet was unaccounted for. The current written confirmation of warfarin regimes from the prescriber were not kept in the medicines kardex; for one patient an obsolete written confirmation of their warfarin regime was in the medicines kardex. There was no evidence that transcribing of warfarin dosage instructions onto warfarin administration charts involved two staff. A requirement was made.

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 manufacturers' 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

Safe systems must be in place for the management of warfarin. A requirement was made.

Number of requirements:	1	Number of recommendations	0

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 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. 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 also advised that a pain assessment was completed as part of the admission process and 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 tool was used as needed. A care plan was maintained.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record; however, the fluid consistency was not specified – the acting manager gave an assurance that this would be rectified. Administrations were 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 generally well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included additional records for insulin and transdermal patches. The routes of administration of eye medicines were mostly not recorded on the personal medication records and medicine administration records; a recommendation was made.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for most solid dosage medicines not contained in the monitored dosage blister packs and for transdermal patches. In addition, a quarterly audit was completed by the community pharmacist and a report of the outcome provided to management.

Following discussion with the staff, it was evident that there were good working relationships with other healthcare workers, including the community pharmacist and prescribers.

Areas for improvement

The routes of application of eye medicines should be routinely recorded. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

The administration of medicines to several patients was observed during the inspection. Medicines were administered to the patients in the dining room or in their room. The nurses administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to swallow each medicine. Extra time and attention was given to patients who had difficulty swallowing some of the medicines. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff and patient interaction and communication demonstrated that patients were treated courteously, with dignity and respect. Good relationships were evident.

The patients spoken to advise that they had no concerns in relation to the management of their medicines.

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 knowledgeable of the policies and procedures and that any updates were highlighted to them.

There were robust 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 acting manager and registered nurses, it was evident that staff had a good knowledge of their roles and responsibilities in relation to medicines management.

Staff 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

The issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Debra Ann Hawthorne, Acting 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 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:** 3 September 2016	The registered provider must ensure that safe systems are in place for the management of warfarin.
	Response by registered provider detailing the actions taken: The Warfarin Administration Chart has been amended to record the signature of the Staff Nurse writing and the Staff Nurse verifying the dose being tranferred from the dosage printout, received from practice nurse or Warfarin Clinic. Copies of the most recent RAT are retained in the medicine Kardex for reference purposes. All Warfarin administered must be signed for by 2 Nurses.
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 3 September 2016	The registered provider should ensure that the routes of application of eye medicines are routinely recorded.
	Response by registered provider detailing the actions taken: The Kardex has been re-written stating the appropriate route of application. The Pharmacy have agreed to amend the MARS for the next medication cycle, in the interim the appropriate route has been handwritten on the MARS.

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

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