

Unannounced Medicines Management Inspection Report 25 October 2017



Sandringham

Type of Service: Nursing Home

Address: 24 Sandringham Court, Gilford Road, Portadown, BT63 5BW

Tel no: 028 3839 4194

Inspector: Paul Nixon

www.rgia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 63 beds that provides nursing care for patients with a variety of healthcare needs, as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare Responsible Individual: Dr Maureen Claire Royston	Registered Manager: See box below
Person in charge at the time of inspection: Mrs Tracey Palmer	Date manager registered: Mrs Tracey Palmer Awaiting application – registration pending
Categories of care: Nursing Homes (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment.	Number of registered places: 63 A maximum of 32 in category NH-DE

4.0 Inspection summary

An unannounced inspection took place on 16 October 2017 from 09.40 to 14.25.

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 during and 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 medicine administration, medicine records, medicines storage and the management of controlled drugs.

An area requiring improvement under the standards, in relation to the recording of the use of medicines prescribed on a “when required” basis for the management of distressed reactions, was stated for the second time.

The patients we spoke with were complimentary about the management of their medicines 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

*The area for improvement is one which has been stated for a second time. No new areas for improvement were identified.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Tracey Palmer, 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 13 and 14 September 2017.

5.0 How we inspect

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

- 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.

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection we met with four patients, the manager, four registered nurses and three care staff.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

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
- care plans
- training records
- medicines storage temperatures

Areas for improvements identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

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 13 and 14 September 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be reviewed 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 31 January 2017

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		Validation of compliance
Area for improvement 1 Ref: Standard 18 Stated: First time	The registered provider should ensure that, when a patient is prescribed a medicine for administration on a “when required” basis for the management of distressed reactions, staff record the symptoms of the distressed reaction and the effect of medication administered.	Not met
	Action taken as confirmed during the inspection: Records belonging to three patients were examined. On most occasions, the symptoms of the distressed reaction and the effect of medication administered had not been recorded.	
	This area for improvement has been stated for a second time.	

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.

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 in the last year.

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. 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.

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.

In relation to safeguarding, staff advised that they 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.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. 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.

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. 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 assessments, the management of medicines on admission, controlled drugs and the storage of medicines.

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 generally been administered in accordance with the prescriber's instructions. A couple of medicine audit discrepancies were drawn to the attention of the manager, who gave an assurance that the administrations of these medicines would be closely monitored.

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, three monthly or six monthly medicines were due.

Records belonging to three patients who were prescribed a medicine for administration on a "when required" basis for the management of distressed reactions were examined. The dosage directions were recorded on the personal medication record. However, as stated in section 6.2, on most occasions the symptoms of the distressed reaction and the effect of medication administered had not been recorded. An area for improvement was stated for a second time. A couple of patients were observed to be administered this type of medicine on a regular basis; the need for the prescribers to be requested to review the dosage directions was discussed with the manager and nursing staff.

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. A pain assessment tool was used and 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 and included details of the fluid consistency. 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 injections and transdermal opioid patches.

Practices for the management of medicines were audited throughout the month by the management and staff. This included running stock balances for some solid dosage medicines and inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the manager and staff it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in patient care.

Areas of good practice

There were examples of good practice in relation to care planning and the administration of medicines.

Areas for improvement

No new areas for improvement were identified.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

The administration of medicines to patients was completed in a caring manner, the patient was 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 patients. Staff were noted to be friendly and courteous; they treated the patients with dignity.

The patients we spoke with advised that they were content with the management of their medicines and the care provided in the home. Comments included:

"I am happy here; the staff are great."

"The care is good."

"It's great here; the staff are great."

"It's great here; I am well cared for."

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 process, we issued questionnaires to patients, patients' representatives and staff. Four patients and three patient's representatives completed and returned questionnaires within the specified timeframe.

Patients commented as follows:

"I am very happy here, couldn't ask for more."

"Staff are very good, they look after me well."

"I have no worries about my tablets; the nurses do all that for me."

Patients' representatives commented as follows:

"I am very happy with my mother's care; I have no issues."

"Very professional nurses, they're great!!"

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home. Staff listened to patients and took account of their views.

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.

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 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. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following 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 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 manager, registered nurses and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

The area for improvement from the last medicines management inspection had not been addressed. To ensure that any areas for improvement are fully addressed and the improvement sustained, it was suggested to the manager that the QIP should be regularly reviewed as part of the quality improvement process.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that management were open and approachable and willing to listen.

Three members of staff completed and returned questionnaires within the specified timeframe. Comments received were positive; with responses recorded as 'very satisfied' or 'satisfied' with the management of medicines in the home.

Areas of good practice

There were examples of good practice in relation to the management of medicine incidents and maintaining good working relationships. 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

The areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Tracey Palmer, 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 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 18 Stated: Second time To be completed by: 24 November 2017	<p>The registered provider should ensure that, when a patient is prescribed a medicine for administration on a “when required” basis for the management of distressed reactions, staff record the symptoms of the distressed reaction and the effect of medication administered.</p> <p>Ref: 6.2 and 6.5</p>
	<p>Response by registered person detailing the actions taken:</p> <p>A review has taken place of all prn medications with residents own GP's. Regularly taken prn medication has now been prescribed on a regular basis. The symptoms of distressed reactions and the effect of the medication administered and the importance of recording this by staff has been discussed through supervision and at a trained staff meeting. Registered Manager will conduct spot checks and evidence this as part of ongoing monitoring.</p>

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



The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Email info@rqia.org.uk
Web www.rqia.org.uk
 [@RQIANews](https://twitter.com/RQIANews)

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