The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report
7 March 2017

Seapatrick

Type of Service: Nursing Home
Address: 80 Lurgan Road, Seapatrick, Banbridge, BT32 4LY
Tel no: 02840628289
Inspectors: Paul Nixon and Frances Gault

1.0 Summary

An unannounced inspection of Seapatrick took place on 7 March 2017 from 10:05 to 13:20.

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 systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. It was evident that the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. There were no areas for improvement identified.

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. There were no areas for improvement identified.

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. Although there was little response from patients in relation to their medicines, those spoken with were very satisfied with their care. There were no areas for 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 for 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 prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

1.1 Inspection outcome

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Edel McCaughley, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent finance inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 30 August 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Mrs Edel McCaughley
Person in charge of the home at the time of inspection: Mrs Edel McCaughley	**Date manager registered:** 18 March 2015
Categories of care: NH-MP(E), NH-I, NH-DE, NH-PH	**Number of registered places:** 60

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, the registered manager, three registered nurses, four care staff, and one patient’s representative.

Twenty-five questionnaires were issued to patients, patients’ representatives and staff with a request that they were returned within one week from the date of this inspection.

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.

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
- care plans
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 30 August 2016

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

4.2 Review of requirements and recommendations from the last medicines management inspection dated 24 June 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must closely audit liquid medicines and food supplements to ensure that they are administered as prescribed. **Action taken as confirmed during the inspection**: There was evidence that liquid medicines and food supplements were audited to ensure they were administered as prescribed. Audits performed as part of the inspection process produced satisfactory outcomes.	**Met**
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that staff dispose of sharps immediately after use in accordance with recognised guidance. **Action taken as confirmed during the inspection**: From discussion with the nursing staff and observations made, it was evident that sharps were immediately disposed of after use.	**Met**

<table>
<tr><td rowspan="2">Requirement 3

Ref: Regulation 13(4)

Stated: First time</td><td>The registered manager must reinvestigate medication incident (48871) to determine if the identified patient has been injected with a previously used insulin needle?

A Form 2 should be forwarded to RQIA quoting reference number 48871</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
This issue was investigated and the follow-up incident Form 2 was sent to RQIA on 29 July 2013. No further action was required.</td></tr>
<tr><td rowspan="2">Requirement 4

Ref: Regulation 13(4)

Stated: First time</td><td>The registered manager is required to investigate the discrepancy noted in one patient’s insulin and send a written report of the outcome to RQIA along with the completed Quality Improvement Plan.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The registered manager investigated the discrepancy noted in one patient’s insulin and concluded that there had been no discrepancy in the patient’s insulin; the insulin dose had been increased by the GP and staff were required to give extra insulin to compensate while waiting on a new medicine administration record sheet.</td></tr>
<tr><td rowspan="2">Requirement 5

Ref: Regulation 13(4)

Stated: First time</td><td>The registered manager must ensure that medicine administration records accurately reflect the time of administration and to ensure that appropriate dosage intervals are observed.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The medicine administration records had been accurately completed to reflect the time of administration of medicines and to ensure that appropriate dosage intervals were observed.</td></tr>
<tr><td>Requirement 6

Ref: Regulation 13(4)

Stated: First time</td><td>The registered manager must ensure that the management of thickened fluids is reviewed and revised.</td><td>Met</td></tr>
</table>

	Action taken as confirmed during the inspection: The management of thickened fluids had been reviewed and revised. The required consistency was documented on the Speech and Language Therapist reports, care plans, personal medication records and food and fluid intake charts. A record of administration was maintained by nurses and care staff.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should ensure that obsolete dosage regimes are removed from the files. **Action taken as confirmed during the inspection**: Only current dosage regimes were in the medicine kardex files.	**Met**
Recommendation 2 **Ref**: Standard 37 **Stated:** First time	The registered manager should monitor the length of time taken to complete the morning medicines rounds to ensure that appropriate dosage intervals are observed between the administrations of medicines. **Action taken as confirmed during the inspection**: The morning medicines round was completed to ensure that appropriate dosage intervals were observed between the administrations of medicines.	**Met**

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. 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.

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.

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. warfarin and insulin. The use of separate administration charts was acknowledged.

Appropriate arrangements were in place for administering medicines in disguised form. There was written consent from the general medical practitioners to cover this arrangement and care plans were in place.

Discontinued or expired medicines were disposed of appropriately. The nursing staff advised that discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Medicines were generally stored safely and securely and in accordance with the manufacturer's instructions. However, in the general nursing unit, creams in use were observed to all be kept in a basin. This infection control issue was discussed with the registered manager, who gave an assurance that it would be addressed without delay. Storage capacity remains limited in the general nursing unit with little working space available for nurses to undertake medicine related tasks. 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?

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, fortnightly and 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 the 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. A care plan was maintained. In the dementia unit, there had been no recent use of medication in this manner. In the general nursing unit, for one patient, the reason for and the outcome of administration were generally not recorded. This matter was discussed with the registered manager, who gave an assurance that it would be addressed without delay.

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

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.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for solid dosage medicines not dispensed in the monitored dosage system blister packs and for some inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that, when applicable, other healthcare professionals are contacted in response to patients' 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.

Patients advised that they were very satisfied with the care experienced. An activity therapist was visiting the general nursing unit during the inspection; they were playing the guitar and enjoying a sing-a-long with some residents. A befriender for people with dementia was visiting the home to take a resident out for a coffee. She spoke positively of the "side by side" service being provided.

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. Comments received were very positive; the responses were recorded as 'satisfied' or 'very satisfied' with the management of medicines in the home.

Eight members of staff also completed a questionnaire. The responses were positive and raised no concerns about the management of medicines in the home.

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. 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.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was usually 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 staff, 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.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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

Assurance, Challenge and Improvement in Health and Social Care