

# Unannounced Medicines Management Inspection Report 31 January 2018



## Seapatrick

**Type of Service: Nursing Home**  
**Address: 80 Lurgan Road, Seapatrick, Banbridge, BT32 4LY**  
**Tel no: 028 4062 8289**  
**Inspector: Paul Nixon**

[www.rqia.org.uk](http://www.rqia.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 60 beds that provides care for patients with a variety of care needs, as detailed in section 3.0.

### 3.0 Service details

<b>Organisation/Registered Provider:</b> Four Seasons Healthcare  <b>Responsible Individual:</b> Dr Maureen Claire Royston	<b>Registered Manager:</b> See box below
<b>Person in charge at the time of inspection:</b> Ms Louise Riley	<b>Date manager registered:</b> Ms Louise Riley – Registration pending
<b>Categories of care:</b> Nursing Homes I – Old age not falling within any other category. DE – Dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. PH – Physical disability other than sensory impairment.	<b>Number of registered places:</b> 60 Includes a maximum of 39 patients in category NH-DE located in the Dementia Unit and a maximum of 21 patients located in the General Unit. Category NH-PH for 1 identified person only and category NH-MP(E) for 1 identified person only.

### 4.0 Inspection summary

An unannounced inspection took place on 31 January 2018 from 09.45 to 14.00.

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

One area requiring improvement was identified in relation to the care planning and recording of medicines prescribed on a “when required” basis for the management of distressed reactions.

The patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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
<b>Total number of areas for improvement</b>	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Ms Louise Riley, 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 16 August 2017. 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 three patients, one patient's representative, the manager, three registered nurses and four care staff.

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
- controlled drug record book
- medicine audits
- care plans
- training records
- 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 16 August 2017

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 7 March 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.**

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. 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. Safeguarding training had been completed by staff.

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and medicines administered through a feeding tube.

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

**Areas for improvement**

No areas for improvement were identified during the inspection.

	Regulations	Standards
<b>Total number of areas for improvement</b>	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, fortnightly and three 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 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. For two of three patients whose records were examined, a care plan was maintained and the reason for and the outcome of administration were recorded. However, for one patient who had recently been administered the medicine on a significant number of occasions, a care plan was not maintained and the reason for and outcome of administration had never been recorded. An area for improvement was identified.

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 well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included additional records for transdermal opioid patches and warfarin.

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

Following discussion with the manager and staff, it was evident that other healthcare professionals are contacted when required to meet the needs of patients. 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 the standard of record keeping and the administration of medicines.

### **Areas for improvement**

Whenever a patient is prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, there should be a care plan and the reason for and outcome of administration should be routinely recorded.

	<b>Regulations</b>	<b>Standards</b>
<b>Total number of areas for improvement</b>	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.**

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, good relationships were observed between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity. Staff were observed assisting patients with breakfast.

Patients spoken to at the inspection advised that they liked the home and staff. One patient’s representative advised that they were very satisfied with the care provided.

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.

No completed questionnaires from patients and their representatives were returned within the specified timeframe.

**Areas of good practice**

Staff listened to patients and relatives and took account of their views.

**Areas for improvement**

No areas for improvement were identified during the inspection.

	<b>Regulations</b>	<b>Standards</b>
<b>Total number of areas for improvement</b>	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. These were not examined. Following discussion with staff it was evident that they were knowledgeable with the policies and procedures and that any updates were highlighted to them. Staff were familiar with their roles and responsibilities in relation to medicines management.

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 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.

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

No members of staff shared their views by completing an online questionnaire.

### 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
<b>Total number of areas for improvement</b>	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 Ms Louise Riley, 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

<p><b>Area for improvement 1</b></p> <p><b>Ref:</b> Standard 18</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 2 March 2018</p>	<p>The registered person shall ensure that, whenever a patient is prescribed a medicine for administration on a “when required” basis for the management of distressed reactions, there is a care plan and the reason for and outcome of administration are routinely recorded.</p> <p>Ref: 6.5</p>
	<p><b>Response by registered person detailing the actions taken:</b></p> <p>The findings of the inspection have been discussed with nursing staff at a staff meeting on 9.02.18. The importance of having a care plan in place for PRN medications has been reiterated to them. The home manager has also asked that an entry be made in a resident's progress notes detailing the distressed reaction and then the subsequent effect of the PRN medication. Compliance with this will be monitored on an ongoing basis by carrying out weekly and monthly medication audits.</p>

*\*Please ensure this document is completed in full and returned via the 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

**Email** [info@rqia.org.uk](mailto:info@rqia.org.uk)

**Web** [www.rqia.org.uk](http://www.rqia.org.uk)

 [@RQIANews](https://twitter.com/RQIANews)

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