Unannounced Medicines Management Inspection Report
1 November 2016

Iveagh House

Type of Service: Nursing Home
Address: 62 Castlewellan Road, Banbridge, BT32 4JD
Tel no: 028 4062 8055
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Iveagh House took place on 1 November 2016 from 10.20 to 14.20.

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 working relationship with the community pharmacist, 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. No requirements or recommendations were 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. No requirements or recommendations were 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. No requirements or recommendations were made.

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. No requirements or recommendations were made.

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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Iveagh House which provides both nursing and residential care.

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 Ms Patricia Purvis, Registered Manager, and Ms Louise Knox, Sister, 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 care inspection

There were no further actions required to be taken following the most recent inspection on 18 July 2016.

2.0 Service details

Registered organisation/registered person: Mr Harold Leslie Mitchell	**Registered manager:** Ms Patricia Purvis
Person in charge of the home at the time of inspection: Ms Louise Knox (10.20 – 12.45) Ms Patricia Purvis (12.45 – 14.20)	**Date manager registered:** 23 March 2015
Categories of care: RC-I, NH-I	**Number of registered places:** 33

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 four patients, two care assistants, two registered nurses and the registered manager.

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
- 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 18 July 2016

The most recent inspection of the home was an unannounced care inspection. No requirements or recommendations were made.

4.2 Review of requirements and recommendations from the last medicines management inspection 23 June 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must monitor the maintenance of the records which are maintained for the management of thickening agents to ensure that thickening agents are being administered in accordance with the prescribers' instructions on every occasion.	**Met**
	Action taken as confirmed during the inspection: A revised recording system was in place. The registered manager and sister confirmed that these records were audited regularly.	
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that accurate and complete records for the administration of external preparations are maintained on all occasions.	**Met**
	Action taken as confirmed during the inspection: The sample of records which were reviewed at the inspection had been accurately maintained.	
Requirement 3 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must investigate the apparent discrepancy in the administration of spironolactone and vitamin BPC capsules for Patient A. A copy of the findings and action taken to prevent a recurrence must be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: The investigation was completed and an action plan was implemented to prevent a recurrence.	

Requirement 4 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that all medicines are available for administration.	**Met**
	Action taken as confirmed during the inspection: All medicines were available for administration as prescribed on the day of the inspection. The registered nurses advised that robust stock control systems were in place.	
Requirement 5 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that administration records are signed following the medicine administration and not prior to administration.	**Met**
	Action taken as confirmed during the inspection: Registered nurses confirmed that the records of administration were not signed prior to administration and this was evidenced at the inspection.	
Requirement 6 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that the refrigerator temperature is maintained between 2 ^{o}C and 8 ^{o}C.	**Met**
	Action taken as confirmed during the inspection: A review of the daily records indicated that temperatures were being maintained within the accepted range of 2 ^{o}C and 8 ^{o}C.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should audit all aspects of the management of medicines at regular intervals.	**Met**
	Action taken as confirmed during the inspection: The registered manager completes a monthly medicines management audit tool. Records were available for inspection.	

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.

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 medication 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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged. Staff were reminded that warfarin should be referenced on the personal medication records. It was agreed that the records would be updated following the inspection.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. Staff were reminded that zopiclone tablets must be denatured prior to their disposal.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Medicine refrigerators and oxygen equipment were checked at regular intervals. There were systems in place to alert staff of the expiry dates of most medicines with a limited shelf life, once opened. Staff were reminded that liquid antibiotics have a limited shelf-life once reconstituted.

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 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. Care plans were maintained. 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.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff advised that a pain assessment tool was used with patients who could not verbalise their pain.

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. Care plans and speech and language assessment reports were in place. Registered nurses recorded administration on the medication administration records and care staff used separate recording sheets.

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. This was discussed with regard to two patients.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the separate recording systems for transdermal patches.

Practices for the management of medicines were audited throughout the month by both staff and management. This included running stock balances for medicines which were not contained within the monitored dose system. 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 were contacted in response to medication related issues.

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

Throughout the inspection, there was evidence of good relationships with the staff and patients, and that the patients' needs and choices were being met.

Following discussion with patients, it was ascertained that they had no concerns regarding the management of their medicines and that they were content with their care in the home.

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. Management advised that they had recently been reviewed. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. The medicine related incident reported since the last medicines management inspection was 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. The registered manager confirmed that any issues would be discussed with staff for corrective action.

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. They advised that any resultant action was communicated with staff either individually or at team meetings.

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.

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