Unannounced Medicines Management Inspection Report
5 May 2017

Sanville

Type of Service: Nursing Home
Address: 17b Annagher Road, Coalisland, Dungannon, BT71 4NE
Tel no: 028 8774 8005
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Sanville took place on 5 May 2017 from 10.15 to 15.00.

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. 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. 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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Sanville 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 Claire Reid, Acting 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 care inspection

There were no further actions required to be taken following the most recent inspection on 7 February 2017.

2.0 Service details

Registered organisation/registered person: Mrs Alice McAleer &Mr Brendan Gervin	**Registered manager:** See below
Person in charge of the home at the time of inspection: Ms Claire Reid	**Date manager registered:** Ms Claire Reid – application received - registration pending
Categories of care: NH-I, NH-PH, RC-I, NH-DE, NH-LD, NH-LD(E), NH-MP(E), NH-MP	**Number of registered places:** 41

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; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

We met with four patients, two registered nurses and the acting manager.

Fifteen questionnaires were issued to patients, relatives/patients' representatives and staff, with a request that they were returned within one week from the date of the inspection.

A sample of the following records was examined:

- 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 7 February 2017

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

4.2 Review of requirements and recommendations from the last medicines management inspection dated 20 May 2016

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 28 **Stated:** First time	The level of audit activity on liquid form medicines should be increased.	**Met**
	Action taken as confirmed during the inspection: The acting manager had developed and implemented an audit tool to monitor the administration of liquid form medicines.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. The impact of training was monitored through the audit process, team meetings, supervision and annual appraisal. Competency assessments were completed annually. Update training on the management of warfarin, controlled drugs, and medicines ordering and receipt was provided by the acting manager in February 2017 and April 2017. Care assistants had received training on the application of emollient preparations and thickening agents.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. There was evidence that recently prescribed medicines and antibiotics were received without delay.

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. Satisfactory arrangements were also in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses. This safe practice was acknowledged.

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. The acting manager advised that all registered nurses would be reminded that any transcribing should be verified and signed by two registered nurses.

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 regularly. A number of discontinued eye preparations were available on the medicine trolley; the registered manager removed these for disposal during the inspection. It was agreed that some inhaler spacer devices would be removed for disposal.

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 majority of medicines examined had been administered in accordance with the prescriber's instructions. A small number of discrepancies were identified; these were discussed in detail with the acting manager and it was agreed 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, monthly or 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. Care plans were in place. 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 in the daily care notes. There was evidence that the care plans were being reviewed regularly.

The management of pain was examined. Care plans were in place and a pain assessment tool was used for those patients who could not verbalise their pain. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable.

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. Records of administration were maintained.

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. Each patient had a cover sheet providing information on their GP, emergency contact, allergies and dietary requirements.

The robust auditing system which had been implemented following previous inspections had been sustained. In addition to the acting manager's monthly audit, registered nurses maintained running stock balances for several solid dosage medicines and inhaled medicines.

The acting manager and staff confirmed that other healthcare professionals are 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?

We observed the morning medication round. Registered nurses administered medicines to patients in a caring manner. It was apparent that staff were aware of patients' individual needs and preferences.

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

We spoke with four patients who were complimentary about the care provided. Medicines were discussed with one patient who advised that they were happy for registered nurses to administer their medicines and that pain relief was administered without delay.

As part of the inspection process questionnaires were issued to patients, relatives/ representatives and staff, with a request that they were returned within one week from the date of the inspection. Five patients, five relatives and three members of staff completed and returned the questionnaires. The responses were positive and these were recorded as, "very satisfied" with regard to the management of medicines in the home.

Comments made included:
"Very well run home, well managed, just great."
"I am very well looked after here and it feels like my own home now I am settled here."

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 these were due for review. 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 and were aware that some medication related incidents may need to be reported to the safeguarding team.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. The acting manager advised that any discrepancies and subsequent learning/action plans would be discussed with registered nurses without delay.

Following discussion with the acting manager and registered nurses, 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 them either individually or during staff handovers.

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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