Unannounced Medicines Management Inspection Report
20 May 2016

Sanville

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 20 May 2016 from 10:00 to 15:25.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern though one area for improvement was identified and is set out in the quality improvement plan (QIP) within this report.

Is care safe?
No requirements or recommendations have been made.

Is care effective?
One recommendation regarding auditing the administration of liquid form medicines has been made.

Is care compassionate?
No requirements or recommendations have been made.

Is the service well led?
No requirements or recommendations have been 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 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	1

Details of the QIP within this report were discussed with Mrs Alice McAleer, Registered Person and Ms Claire Reid, Acting 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.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the most recent inspection on 19 April 2016.

2.0 Service details

Registered organisation/registered person: Mrs Alice McAleer & Mr Brendan Gervin	**Registered manager:** See box below.
Person in charge of the home at the time of inspection: Ms Claire Reid	**Date manager registered:** Ms Claire Reid – Acting – No Application Required
Categories of care: RC-I, NH-I, NH-PH, NH-DE, NH-LD, NH-LD(E), NH-MP(E), NH-MP	**Number of registered places:** 38

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the incidents register - it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

The inspector met with two registered nurses, one senior carer, one patient and their relative.

The following records were 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 19 April 2016

The most recent inspection of the home was an unannounced care inspection. The draft report has been issued.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 28 May 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 28 **Stated:** First time	It is recommended that the registered person ensures that the level of audit activity is increased.	**Met**
	Action taken as confirmed during the inspection: The level of audit activity has increased. Daily stock counts were carried out on medicines which were not contained within the blister pack medicines system. The acting manager completed monthly audits with evidence that action plans were developed and implemented. This recommendation as written has been addressed. However, audit discrepancies in the administration of a number of liquid form medicines were observed. A recommendation regarding the auditing of liquid form medicines was therefore made.	
Recommendation 2 **Ref:** Standard 28 **Stated:** First time	It is recommended that the registered person ensures that dates of opening are recorded on all medicines in order to facilitate audit activity and disposal at expiry.	**Met**
	Action taken as confirmed during the inspection: The date of opening had been recorded on all medicines selected for audit at this inspection. All medicines were observed to be in date.	

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 on the management of warfarin, controlled drugs and receiving medicines into the home was provided in March 2016. The most recent training was in relation to dysphagia.

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 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, insulin and medicines via the enteral route. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. It was not always clearly recorded that controlled drugs were denatured prior to their disposal. The acting manager agreed to discuss this finding with all registered nurses for corrective action.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were 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?

With the exception of liquid form medicines the sample of medicines examined had been administered in accordance with the prescriber's instructions; audit discrepancies were observed for a number of liquid form medicines. The acting manager had identified that liquid form medicines were not being audited and a new auditing system for liquid form medicines was due to be implemented on 21 May 2016. A recommendation regarding auditing liquid form medicines was made.

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, 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. These medicines had not been required recently. The acting manager confirmed that when they are used the reason for and the outcome of administration are recorded. Care plans were in place.

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. Staff advised that most of the patients could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment was completed as part of the admission process.

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. Each administration was 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 the layout of the medication administration recording sheets and the transdermal patch application charts.

Practices for the management of medicines were audited throughout the month by the registered nurses and the management team. This included running stock balances for several solid dosage medicines, including inhaled medicines.

Following discussion with the acting manager and registered nurses, it was evident that when applicable, other healthcare professionals are contacted in response to medicine related issues.

Areas for improvement

The level of audit activity on liquid form medicines should be increased. Any discrepancies should be investigated and reported to the appropriate authorities if necessary. A recommendation has been made.

Number of requirements	0	Number of recommendations	1

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.

We spoke to one patient who confirmed that she wanted the registered nurses to administer her medicines. She advised that she could request additional analgesia if required. The patient's relative said that she was very happy with the care provided in the home. She stated that there was a lovely atmosphere in the home and that her relative enjoyed the company of other patients and their visitors.

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; they had been updated in the last year. Following discussion with one of the registered nurses 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. No medicine related incidents had been reported since the last medicines management inspection.

A review of the home's 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 acting manager, the registered nurses and one senior carer, 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 all staff through staff handovers and 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

The issue identified during this inspection is detailed in the QIP. Details of this QIP were discussed with Mrs Alice McAleer, Registered Person, and Ms Claire Reid, Acting Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person to ensure that the recommendation contained within the QIP is 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 your premises. 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and the DHSSPS Care Standards for Nursing Homes (2015). They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to pharmacists@rqia.org.uk and assessed by the inspector.

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 person/manager from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 20 June 2016	The level of audit activity on liquid form medicines should be increased. **Response by registered person detailing the actions taken:** The level of audit activity has increased and as discussed end of bottle audits completed from day of inspection. Spot checks of liquid medications being carried out. Any discrepancies will be addressed and reported as needed.

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address

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