Unannounced Medicines Management Inspection Report
7 June 2016

Faith House

Type of Service: Nursing Home
Address: 25 Orpen Park, Belfast, BT10 0BN
Tel No: 028 9061 2318
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Faith House took place on 7 June 2016 from 10.55 to 15.55.

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 two areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

Is care safe?

One recommendation has been made in relation to the management of handwritten medication administration records (MARs).

Is care effective?

One recommendation has been made in relation to care plans for the management of pain and distressed reactions.

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 Faith 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**	**2**

Details of the QIP within this report were discussed with the registered manager, Mrs Jane Moore, 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 QIP there were no further actions required to be taken following the most recent inspection on 19 May 2016.

2.0 Service details

Registered organisation/registered person: Board of Trustees - Faith House/ Mr Mervyn Wishart	**Registered manager:** Mrs Jane Moore
Person in charge of the home at the time of inspection: Mrs Jane Moore	**Date manager registered:** 9 January 2015
Categories of care: RC-I, NH-I, NH-PH, NH-TI	**Number of registered places:** 65

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

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

We met with the registered manager, two registered nurses, two senior care assistants and one patient.

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 19 May 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be assessed by the care inspector upon return. This QIP will be validated by the care inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 20 February 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must closely monitor food supplements and eye preparations to ensure that they are removed from use once the date of expiry is reached.	**Met**
	Action taken as confirmed during the inspection: The date of opening was marked on all food supplements and eye preparations examined. None had reached their expiry date. The registered manager and staff stated that this had been reviewed and discussed with staff following the last inspection and was being monitored on a regular basis. This was evident in audit records and action plans.	

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, senior care staff and care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and appraisal. Competency assessments were completed following training. Refresher training was underway on the day of the inspection.

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.

The arrangements in place to manage changes to prescribed medicines were examined. Personal medication records were updated by two designated staff. Handwritten entries on medication administration records were not always updated by two staff in accordance with the home's own procedures. A recommendation was made.

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.

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. A new storage area was in place adjacent to the treatment room. This has increased the space available for the storage of medicine trolleys. The registered manager was advised that the temperature of both storage areas should be monitored, this was in place for one storage area.

Areas for improvement

Handwritten entries on medication administration records should be checked and signed by two trained members of staff. A recommendation was made.

Number of requirements	0	Number of recommendations	1

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 robust 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. The reason for and the outcome of any administration were recorded. A care plan was sometimes in place; this should be in place where relevant and detail the management of distressed reactions for the individual.

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 a pain assessment was completed as part of the admission process. A care plan was not always maintained; this should be in place where relevant and detail the management of pain for the individual. A recommendation was made regarding the development of care plans.

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 prescribed fluid consistency. Care plans and speech and language therapy assessment reports were in place. For one patient the prescribed consistency in the care plan and on the personal medication record did not correlate. The registered manager agreed to address this issue immediately.

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 use of additional administration records for several medicines.

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

It was evident that when applicable, other healthcare professionals were contacted regarding the management of medicines.

Areas for improvement

Care plans should be developed further for the management of pain and distressed reactions for individual patients. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

Appropriate arrangements were in place to facilitate patients responsible for the self-administration of medicines.

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.

One patient advised that they were satisfied with the manner in which medicines were managed and administered and were complimentary about the care received.

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. These had been recently reviewed and revised. 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. Medicine related incidents reported since the last medicines management inspections were discussed. There was evidence of the action taken and learning implemented following incidents.

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 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

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager, Mrs Jane Moore, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager 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 provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider 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 Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to pharmacists@rqia.org.uk for review 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 provider 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 provider 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 29 **Stated:** First time **To be completed by:** 8 July 2016	The registered person should ensure that handwritten entries on medication administration records are checked and signed by two trained members of staff. **Response by registered person detailing the actions taken:** All staff are aware of the importance of ensuring all hadwritten entries are checked and signed by two nurses. Audits being completed to ensure compliance.
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 8 July 2016	The registered person should ensure that care plans are developed further for the management of pain and distressed reactions for individual patients. **Response by registered person detailing the actions taken:** Care plans reviewed to ensure all include management of pain and distressed reactions for those patients requiring these drugs. Audits will be ongoing to ensure compliance from all staff.

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

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