Unannounced Medicines Management Inspection Report
2 May 2018

Tennent Street

Type of Service: Nursing Home
Address: Balmoral and Sandhurst Suites, 1 Tennent Street, Belfast, BT13 3GD
Tel No: 028 9031 2318
Inspector: Judith Taylor

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 27 beds that provides care for patients living with a range of healthcare needs as detailed in Section 3.0.

This home is situated on the same site as Tennent Street (Hampton Suite) residential care home and Tennent Street (Sandringham Suite) nursing home.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** See box below
Person in charge at the time of inspection: Ms Sheila Mae Hechanova (Acting Manager)	**Date manager registered:** Ms Sheila Mae Hechanova (Acting - no application required)
Categories of care: Nursing Homes (NH): DE – Dementia A – Past or present alcohol dependence	**Number of registered places:** 27 comprising: - NH-DE - a maximum of 14 persons in the Balmoral Suite - NH-A - a maximum of 13 persons in the Sandhurst Suite The home is also approved to provide care on a day basis to one person in the Balmoral Suite.

4.0 Inspection summary

An unannounced inspection took place on 2 May 2018 from 10.40 to 13.55.

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 the governance arrangements, training and competency assessment, administration of medicines, medicine storage and controlled drugs.

Areas requiring improvement were identified in relation to the management of distressed reactions and care plans.

Patients were noted to be relaxed and comfortable in their surroundings and in their interactions with staff. The patients we met with spoke positively about their care and their well-being. We noted the warm and welcoming atmosphere in the home.

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
Total number of areas for improvement	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Ms Sheila Mae Hechanova, 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 19 March 2018. 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.

A poster was displayed to inform visitors to the home that an inspection was being conducted.

During the inspection we met with three patients, two registered nurses and the manager.

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
- policies and procedures
- 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 19 March 2018

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 26 May 2016

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. Other training had included the management of dementia and swallowing difficulty.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and for the management of medicine changes. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

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.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed.

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. Care plans were maintained.

Appropriate arrangements were in place to crush medicines prior to administration and/or add medicines to food to aid swallowing. Care plans were maintained.

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, controlled drugs and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	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 or three monthly medicines were due. Reminders were marked out on the medication administration records.

Epilepsy management plans were located in the care files and medicine folders.

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. A care plan was 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. There was evidence that some of the patients

were being administered these medicines on a regular basis. This should be referred to the prescriber for review. The reason for and the outcome of administration were occasionally recorded. This should be recorded on every occasion. 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. 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. However, it was found that two of the care plans and one personal medication record were not accurate regarding the fluid consistency. The personal medication record was updated at the inspection. Following discussion with the registered nurses and a review of the care plan evaluation notes, it was concluded that the patients were being administered the correct consistency. An area for improvement was identified.

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. They provided details of when the formulation of a medicine was changed e.g. from tablet to liquid, to assist with the patient's ability to swallow the medicine.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for transdermal medicines and antibiotics, protocols for "when required" medicines such as laxatives, analgesics and external preparations.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for most of the medicines which were not supplied in the 28 day blister packs (including liquids, inhaled medicines and insulin) and recording the quantity of medicine carried forward to the next medicine cycle. This good practice was acknowledged. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the manager and staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to patients' healthcare needs.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines. Staff were knowledgeable about the patients' medicines.

Areas for improvement

The management of distressed reactions should be reviewed to ensure that the reason for and outcome of the administration is recorded on every occasion and any regular use is referred to the prescriber.

The care plans regarding the recommended fluid consistency of thickened fluids should be closely monitored to ensure these are accurate at all times.

	Regulations	Standards
Total number of areas for improvement	0	2

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 not observed during this inspection. Following discussion with staff it was confirmed that patients were given time to take their medicines and medicines were given in accordance with the patients' preferences.

Throughout the inspection, it was found that there were good relationships between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity. It was clear from discussion and observation of staff, that they were familiar with the patients' likes and dislikes.

Patients were noted to be participating and enjoying the activities after lunch.

We met with three patients, who expressed their satisfaction with the care, the staff and the manager. They advised that they were administered their medicines on time and any requests e.g. for pain relief, were adhered to. Comments included:

"It's great here."
"The staff are really good."
"I like it, they (staff) are good to me."
"The food is good and they couldn't feed you enough."

Of the questionnaires which were left in the home to receive feedback from patients and their representatives, none were returned with the specified time frame (two weeks). Any comments from patients and their representatives in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas of good practice

Staff listened to patients, took time with the patients and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	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.

The inspector discussed arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. There were arrangements in place to implement the collection of equality data within Tennent Street.

Written policies and procedures for the management of medicines were in place and readily available for staff reference.

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 advised of how incidents were shared with staff to prevent recurrence. 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.

Following discussion with the 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 through team meetings, supervision or individually with staff. They advised that management were open and approachable and willing to listen; and stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

No online questionnaires were completed by staff within the specified time frame (two weeks).

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
Total number of areas for improvement	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 Sheila Mae Hechanova, 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	
Area for improvement 1 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 1 June 2018	The registered person shall ensure that the reason for and outcome of medicines administered to manage distressed reactions is recorded and any regular use referred to the prescriber. Ref: 6.5 **Response by registered person detailing the actions taken:** This has been addressed.The reason for and outcome of medicines administered to manage distressed reactions is now being recorded.Trained staff have had supervision and discussed the importance of referring the patient to the GP for a review if the medication is being taken on a regular basis.
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 1 June 2018	The registered person shall ensure that the care plans in relation to thickening agents are updated to reflect the patient's most recent speech and language therapist's recommendations. Ref: 6.5 **Response by registered person detailing the actions taken:** This has been addressed.Care plans in relation to thickening agents have been updated to reflect the patiant's most recent speech and language therapists' recommendations.

Please ensure this document is completed in full and returned via the Web Portal

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