Unannounced Medicines Management Inspection Report
26 May 2016

Tennent Street
(Balmoral and Sandhurst Suites)

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

1.0 Summary

An unannounced inspection of Tennent Street (Balmoral and Sandhurst Suites) took place on 26 May 2016 from 09.50 to 13.55.

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. A Quality Improvement Plan (QIP) has not been included in this report.

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

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

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

Is the service well led?
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.

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 Mrs Jacquelyn Cairns, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from 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 28 January 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/ Dr Maureen Claire Royston	**Registered manager:** Ms Jacquelyn Grace Cairns
Person in charge of the home at the time of inspection: Ms Jacquelyn Cairns	**Date manager registered:** 04 April 2005
Categories of care: NH-A, NH-DE	**Number of registered places:** 27

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

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 one patient and two registered nurses.

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 28 January 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

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

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37,38 **Stated:** First time	The registered manager should review the management of distressed reactions to ensure that the reason and the effect of administration of the medicine is recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: A review of records indicated that where a medicine was administered to manage a distressed reaction, the reason for the administration and effect of the administration was clearly recorded.	

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 in medicines management was provided through training sessions and completion of e-learning modules. The most recent training was completed in January 2016.

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 robust 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. 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.

Appropriate procedures were in place for the management of medicines administered via an enteral feeding tube.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and very 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.

It was acknowledged that safe systems for medicines management continued to be in place as identified at this and the previous medicines management inspection and there was evidence over time of positive outcomes for patients.

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. A detailed care plan was maintained. The reason for and the outcome of the administration were recorded on each occasion. 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 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. The registered nurses provided examples of where this had occurred.

Medicine records were well maintained and readily facilitated the audit process. The good standard of record keeping and the use of additional administration records for a number of medicines was acknowledged. Staff were commended on the robust filing systems in place and the ease of retrieval of records.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to issues or concerns regarding medicines management.

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?

A small number of patients were responsible the self-administration of external preparations. A risk assessment for each patient was in place and staff monitored compliance.

The administration of medicines to patients was completed in a caring manner; the patients were given time to take their medicines and medicines were administered as discreetly as possible.

Medicines management was discussed with one patient. This patient spoke positively of the management of their medicines and their relationship with staff. For those patients who could not verbalise their feelings in respect of their care, they were observed to be relaxed and comfortable in their surroundings.

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 updated in March 2016 and were available in each of the treatment rooms. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

In relation to the management of dementia, the registered manager advised that all grades of staff were in the process of completing an 18 week programme - Dementia Care Framework. She explained that this home was one of three pilot homes selected for the completion of this framework. She advised that this involved staff being trained in how the patient experiences dementia including their sensory experience. She provided examples of scenarios completed by staff. In relation to medicines management she advised that this framework detailed the management of distressed reactions, pain and communication. The involvement in initiatives like this indicates that this service is seeking to make positive changes to benefit patients and includes all members of the staff team to implement these changes.

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 they were made aware of incidents. There had been no medicine related incidents reported since the last medicines management inspection.

A robust auditing process for medicines management was observed. There was evidence that this auditing process was well embedded into routine practice. The management of medicines was audited throughout the month by the registered nurses and the registered manager. The audits included running stock balances for several solid dosage medicines, liquid medicines and inhaled medicines and review of medicine records and medicine equipment. In addition, a quarterly audit was completed by the community pharmacist. The audit process was readily facilitated by recording the date of opening on medicines and also recording the quantity of medicine carried forward from the last medicine cycle. A review of the audit records indicated that there were rarely any discrepancies. However, where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice. No discrepancies were observed in the outcomes of the audit trails performed at the inspection.

Following discussion with the registered manager and registered nurses, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. They advised that they had received the training for their work, including specialised training in specific areas and could access further training when required.

Staff advised that management were open and approachable and willing to listen. They stated that there were good working relationships within the home, with relatives and with healthcare professionals involved in patient care.

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.

It was acknowledged that robust systems for medicines management were in place and the evidence indicated that this has promoted the delivery of positive outcomes for patients over time.

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.

The Regulation and Quality Improvement Authority

9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews