Unannounced Medicines Management Inspection Report
22 April 2016

Lisburn Intermediate Care Centre

119b Hillsborough Road, Lisburn, BT28 1JX
Tel No: 028 9266 9523
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Lisburn Intermediate Care Centre took place on 22 April 2016 from 10.10 to 15.45.

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?
One recommendation has 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 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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to the DHSSPS Nursing Homes Minimum Standards, February 2008.

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 Judith Derby, Registered Manager and Ms Lorraine Thompson, Regional 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 estates inspection

There were no further actions required to be taken following the most recent inspection on 11 February 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/ Dr Maureen Claire Royston	**Registered manager:** Mrs Judith Derby
Person in charge of the home at the time of inspection: Mrs Judith Derby	**Date manager registered:** 6 September 2013
Categories of care: NH-TI, NH-PH(E), NH-PH, NH-I, NH-DE There shall be a maximum of 12 patients accommodated within category of care NH-DE and located within the designated dementia unit (lower ground floor).	**Number of registered places:** 63

3.0 Methods/processes

Prior to inspection we analysed the following records:

- 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

We met with three patients, three registered nurses and one member of care staff.

The following records were 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 11 February 2016

The most recent inspection of the home was an announced estates inspection. No requirements or recommendations were made as a result of the inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 3 September 2013

There were no requirements made at the last medicines management inspection.

Last medicine management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 38 **Stated:** First time	The registered person should ensure that the day of administration of medicines which are prescribed on a weekly basis is recorded on the patient's personal medication record.	**Met**
	Action taken as confirmed during the inspection: The day of the administration for weekly medicines was clearly recorded on the personal medication records and printed medication administration records examined.	
Recommendation 2 **Ref**: Standard 38 **Stated:** First time	The registered person should review the recording arrangements for running stock balances on medication administration records (MARs), to ensure the record of administration is clearly segregated from the stock balance.	**Met**
	Action taken as confirmed during the inspection: This had been reviewed. Running stock balances were maintained on the MARs and were segregated from the signatures of administration. Where several doses of the same medicine were administered per day, a running stock balance was recorded at the end of each day.	

Recommendation 3 **Ref**: Standard 38 **Stated:** First time	The registered person should ensure that two nurses are involved in the disposal of medicines into the clinical waste bins and both nurses sign the disposal of medicines record.	**Met**
	Action taken as confirmed during the inspection: Two registered nurses were involved in the disposal of all medicines. Medicines were disposed of in clinical waste bins and denaturing kits were used for the disposal of controlled drugs.	
Recommendation 4 **Ref**: Standard 38 **Stated:** First time	The registered person should ensure that the administration of those medicines highlighted at this inspection and medicines which are prescribed at multiple doses are closely monitored as part of the weekly audit.	**Met**
	Action taken as confirmed during the inspection: Robust auditing arrangements for medicines were observed at the inspection. Audits include a variety of medicines including medicines prescribed at multiple doses. No further medicines discrepancies were identified.	

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. Medicines management training was provided via the completion of e-learning modules and training sessions which included the management of syringe drivers, palliative care and dysphagia. The most recent training was in relation to enteral feeding and the administration of medicines via this route.

The procedures to ensure medicines were ordered and adequate supplies were available should be reviewed. It was noted that there was one medicine which had expired and replacement stock was not available at the time of the inspection and was being followed up by the deputy manager; for one other medicine, two doses had been missed due to being out of stock earlier in the week. A recommendation was made.

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 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.

Appropriate arrangements were in place for administering medicines in disguised form.

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 were checked daily. Staff advised that new medicine refrigerators had been obtained in the last few months. It was noted that the maximum temperatures for one of the refrigerators was continually above the recommended upper limit of 8^{o}C. The stock in this refrigerator was cool. This was discussed and staff advised that this would be followed up with the supplier and a different thermometer would be obtained.

Areas for improvement

The necessary arrangements should be made to ensure that all medicines are available for administration as prescribed and any potential short falls in medicines are readily identified and followed up. 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 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. A care plan was maintained. These medicines were infrequently administered. The reason for and the outcome of the administration was not fully recorded and was discussed. It was agreed that this information would be detailed for any future administration. 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 prescribed 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.

A robust auditing system was evidenced at the inspection. Practices for the management of medicines were audited throughout the month by the staff and management. This included the recording of running stock balances for solid dosage medicines and inhaled medicines. The registered manager provided details of a specific audit tool which had been implemented to ensure that all patients' medicines were audited. A daily quality of life audit tool was also applied to ensure medicines had been administered and records had been completed. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to issues or concerns in relation to 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?

Appropriate arrangements were in place to facilitate patients responsible for the self-administration of medicines. One care plan was updated during the inspection.

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.

The patients spoken to at the inspection advised that they had no concerns in relation to the management of their medicines, and their requests for medicines prescribed on a "when required" basis were adhered to e.g. pain relief.

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 updated. 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 inspection were discussed. There was evidence of the action taken and the learning implemented.

A review of the internal 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

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Judith Derby, Registered Manager and Ms Lorraine Thompson, Regional Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 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:** 23 May 2016	The necessary arrangements should be made to ensure that all medicines are available for administration as prescribed and any potential short falls in medicines are readily identified and followed up. **Response by registered person detailing the actions taken:** 1 expired medicine has a 28 day life span. Protocol put in place that once it is received an alert is recorded 21 days later to remind staff to order it again. PRN Tablet form of the medicine has also been provided by General Practitioner which can be administered in the event of stock not being available. All staff have been informed of the need to be pro-active in ensuring stock is requested in a timely manner.

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