Unannounced Medicines Management Inspection Report
31 January 2017

Templemoyle

Type of Service: Nursing Home
Address: 41a Whitehill Road, Eglinton, BT47 3JT
Tel no: 028 7181 1461
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Templemoyle took place on 31 January 2017 from 10.40 to 14.15.

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.

Is care safe?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. No requirements or recommendations were made.

Is care effective?

The management of medicines supported the delivery of effective care. There were largely satisfactory systems in place to ensure patients were receiving their medicines as prescribed. Areas for improvement were identified in relation to the management of inhaler preparations, record keeping regarding the management of distressed reactions, and records of pain assessment on admission and care plans for the management of pain. Three recommendations were made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for patients. Patients consulted with confirmed that they were administered their medicines appropriately. No requirements or recommendations were made.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. 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.

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 DHSSPS Nursing Homes Minimum Standards, February 2008.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Jeya Pratheeksha, registered 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 QIP there were no further actions required to be taken following the most recent inspection on 16 January 2017.

2.0 Service details

Registered organisation/registered person: Mrs Elizabeth Kathleen Mary Lisk	**Registered manager:** Mrs Jeya Pratheeksha
Person in charge of the home at the time of inspection: Mrs Jeya Pratheeksha	**Date manager registered:** 9 January 2015
Categories of care: NH-I, NH-PH	**Number of registered places:** 30

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; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

We met with two patients, two registered nurses and the registered manager.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

Twenty-five questionnaires were issued to patients, patients' relatives/representatives and staff, with a request that these were completed and returned to RQIA within one week of the inspection.

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 16 January 2017

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

One requirement was made at that inspection in relation to the management of pain, including pain assessment and care planning. This area was also reviewed at this inspection, with respect to medicines management (see section 4.4).

4.2 Review of requirements and recommendations from the last medicines management inspection dated 14 February 2014

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 38 **Stated:** First time	The responsible person should closely review the record keeping pertaining to external preparations as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The method of recording the administration of external preparations was revised following the last inspection. Preparations administered by the registered nurses are recorded on the medication administration record sheets and those administered by designated care assistants are recorded on a separate topical medicines administration record. The registered manager stated that the registered nurses monitor the completion of these records. The sample of records examined had been maintained in a satisfactory manner.	

Recommendation 2 **Ref**: Standard 39 **Stated:** First time	The responsible person should closely monitor the storage of lidocaine plasters to ensure these are sealed when not in use, the date of opening is recorded and each outer sachet is labelled.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that the management of this medicine was reviewed following the last inspection. It was not prescribed for any patient at the time of this inspection. The management of these patches was discussed with the registered manager and nurses and it was evident that these staff were aware of the storage requirements. For this reason this recommendation was assessed as met.	

4.3 Is care safe?

Medicines were managed by staff who had 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 appraisal. Competency assessments were completed annually.

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 medicine 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. 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.

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 mostly been administered in accordance with the prescriber's instructions. Unexplained omissions were noted for two inhaler preparations. Staff were able to discuss the reasons for this, however the management of these medicines should be reviewed to ensure that these medicines are administered as prescribed or a reason for the omission recorded. A recommendation 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, the 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. A care plan was maintained. The reason for and the outcome of administration were recorded on some occasions. These details should be recorded in a consistent manner on every occasion. A recommendation was made.

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 usually maintained. In the records examined, it was not always evident that a pain assessment was completed as part of the admission process. The management of pain should be reviewed to ensure that a pain assessment is completed on admission and the details are clearly recorded in the patient's care plan, including reference to any prescribed analgesia. A recommendation was made.

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. 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. These included the use of transdermal patch application records and separate records of the administration of sedatives and anxiolytic medicines, prescribed for use 'when required'.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several medicines and nutritional supplements. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff and a review of the care files, it was evident that when applicable, other healthcare professionals are contacted in response to concerns about medicines management.

Areas for improvement

The management of the inhaler preparations detailed in the report should be reviewed to ensure that these medicines are administered as prescribed or a reason for the omission recorded. A recommendation was made.

The management of medicines prescribed for use 'when required' for distressed reactions should be reviewed, to ensure that the reason for and the outcome of administration are recorded in a consistent manner on every occasion. A recommendation was made.

The assessment of pain on admission and the detail recorded in the care plan should be reviewed, to ensure that the appropriate information is recorded. A recommendation was made.

Number of requirements	0	**Number of recommendations**	3

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. The patients spoken to were complimentary about their care in the home and about the staff.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As part of the inspection process, questionnaires were issued to patients, relatives/patients' representatives and staff. One patient, one relative and four members of staff completed and returned these within the specified timescale. All of the responses were recorded as 'satisfied' or 'very satisfied' with the medicines management in the home.

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 were not examined. 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 any medicine related incidents. Staff confirmed that they knew how to identify and report incidents.

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 registered manager and 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.

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 the QIP were discussed with Mrs Jeya Pratheeksha, Registered Manager, 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 to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to pharmacists@rqia.org.uk for assessment 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:** 2 March 2017	The registered provider should ensure that the management of the inhaler preparations detailed in the report is reviewed to ensure that these medicines are administered as prescribed or a reason for the omission recorded.
	Response by registered provider detailing the actions taken: StAll staff have be made aware of this issue throught a trained staff meeting and clinical supervision. This is to ensure that medicines are administered as perscribed or a reason for omission.
Recommendation 2 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 2 March 2017	The registered provider should ensure that the management of medicines prescribed for use 'when required' for distressed reactions is reviewed to ensure that the reason for and the outcome of administration are recorded in a consistent manner on every occasion.
	Response by registered provider detailing the actions taken: All staff have be made aware of this issue throught a trained staff meeting and clinical supervision. This will also be recorded on the MARS and the daily progress notes.
Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 2 March 2017	The registered provider should ensure that the assessment of pain on admission and the detail recorded in the care plan is reviewed to ensure that the appropriate information is recorded.
	Response by registered provider detailing the actions taken: Staff have been made aware of the need for assessment of pain on admission if they are on pain relief. This assessment of pain will be regulary reviewed and updated in care plans.

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

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