Unannounced Follow Up Medicines Management Inspection Report 1 April 2019

Maryland Healthcare Care Centre of Distinction

Type of Service: Nursing Home
Address: 95 Knockbracken Road, Castlereagh, Belfast, BT6 9SP
Tel No: 028 9044 8797
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 provider 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 which provides care for up to 84 patients living with care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Maryland Healthcare Limited **Responsible Individual:** Mrs Susan McCurry	**Registered Manager:** Mrs Jacquelyn Grace Woods
Person in charge at the time of inspection: Mrs Jacquelyn Grace Woods	**Date manager registered:** 18 September 2017
Categories of care: Nursing Home (NH): DE – Dementia I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years TI – Terminally ill.	**Number of registered places:** 84 including: NH- DE - 20 patients in Rowan Unit and 20 patients in Larch Unit

4.0 Inspection summary

An unannounced inspection took place on 1 April 2019 from 10.10 to 15.20.

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 previous medicines management inspection on 12 December 2018 had shown that robust arrangements for the management of medicines were not in place. To ensure that the necessary improvements have been made, it was decided that a further medicines management inspection would be completed.

This inspection sought to assess the progress made with the issues raised at the last medicines management inspection and to determine if there were robust arrangements in place for the management of medicines and if the service was well led and delivering safe, effective and compassionate care.

The following areas were examined during the inspection:

- the management of controlled drugs
- medicines records and care plans
- governance arrangements

It was evidenced that the areas identified for improvement had been addressed effectively. Management had reviewed the systems in place, an action plan to resolve issues had been developed and staff had received further training on the management of medicines, their roles and responsibilities and accountability. The evidence seen during the inspection indicated that the management of medicines supported the delivery of safe, effective and compassionate care and that the service was well led. The improvements which had taken place were acknowledged. These must be sustained in order to ensure that staff continue to deliver safe and effective care.

One area for improvement in relation to the completion of records pertaining to controlled drugs was identified.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	0

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Jacquelyn Woods, 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.

4.2 Action/enforcement taken following the most recent medicines management inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the inspection on 12 December 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 by RQIA was being conducted.

During the inspection we met with two registered nurses, the registered manager and the community pharmacist.

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

Areas for improvements identified at the last medicines management inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

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 12 December 2018

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was approved by the pharmacist inspector.

6.2 Review of areas for improvement from the last medicines management inspection dated 12 December 2018

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 29 **Stated:** Second time	The registered person shall monitor the completion of the personal medication records and MARs to ensure that they are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: A significant improvement in the completion of personal medication records and medication administration records (MARs) was evidenced. The registered manager advised of the staff training provided in relation to record keeping and the auditing processes to check these records.	

Area for improvement 2 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that the transcribing of medicines information is verified by two staff and both staff sign the record.	**Met**
	Action taken as confirmed during the inspection: It was evident from examination of several handwritten medicine records that two staff were routinely involved in the transcribing of medicines information.	
Area for improvement 3 **Ref**: Standard 31 **Stated:** First time	The registered person shall review the management of controlled drugs in relation to disposal and transfer.	**Met**
	Action taken as confirmed during the inspection: Following discussion with staff and examination of records, there was evidence that two staff were involved in the disposal or transfer of controlled drugs and were aware that controlled drugs (including those in Schedule 4) must be denatured prior to disposal.	
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that all medicines are appropriately labelled.	**Met**
	Action taken as confirmed during the inspection: All of the medicines examined at the inspection were labelled appropriately.	
Area for improvement 5 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that care plans are updated in relation to medicines management to reflect the patient's needs.	**Met**
	Action taken as confirmed during the inspection: A sample of patients' care plans was examined. In relation to medicines management, the relevant care plans were in place e.g. pain, diabetes, epilepsy, distressed reactions, antibiotics and swallowing difficulty. These were reviewed regularly and were included in the auditing process.	

Area for improvement 6 **Ref**: Standard 18 **Stated:** First time	The registered person shall ensure that the reason for and outcome of medicines administered for distressed reactions is recorded.	**Met**
	Action taken as confirmed during the inspection: A separate chart to record the reason for and outcome of any administration of medicines for distressed reactions was in place.	
Area for improvement 7 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that records of all incoming and outgoing medicines are fully and accurately maintained.	**Met**
	Action taken as confirmed during the inspection: We examined a selection of the receipt and disposal/transfer records; they indicated that staff had recorded details of each medicine.	
Area for improvement 8 **Ref**: Standard 28 **Stated:** First time	The registered person shall review the auditing systems to ensure that they are effective.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the audit system had been reviewed and new monitoring arrangements put in place. The outcomes of the inspection indicate that these auditing systems were effective in identifying shortfalls and driving improvement.	

6.3 Inspection findings

Governance arrangements

Following the last medicines management inspection, we were provided with an action plan to address the issues identified. New audit tools were developed and implemented. Registered nurses had been provided with further training and a copy of the organisation's medicines management policies and procedures; their competencies had been reassessed.

A sample of audit records completed by registered nurses and also the registered manager were provided. There was evidence of the action taken, how issues were shared with staff to address and the systems to monitor improvement. Care plan audits were also completed.

Medicine records and care plans

We examined several patients' medicine records and care plans and evidenced a significant improvement in the standard of record keeping. The majority were well maintained, legible and included the necessary information to direct the care of the patients; this included reminders for medicines which were prescribed at weekly or three monthly intervals. We identified a few missing signatures and discussed these with the registered manager, who provided assurances that this would be addressed.

A range of medicines and medicine formulations were audited. Largely satisfactory outcomes were achieved and indicated that patients were being administered their medicines as prescribed. However, a few small discrepancies were observed and discussed for close monitoring.

There were satisfactory systems in place to manage new admissions, medicine changes and high risk medicines. New charts had been put in place for the safe management of warfarin. All transcribing on warfarin administration records, personal medication records and medication administration records involved two registered nurses. This is safe practice.

A new medicine system had been recently implemented for patient's accommodated on a permanent basis. Staff advised that this was working well. Staff were aware that all medicines must be appropriately labelled and no further concerns regarding labelling were identified.

The management of controlled drugs

We examined the management of controlled drugs. All controlled drugs subject to the safe custody legislation and other controlled drugs, such as Schedule 4 controlled drugs were checked at each shift change.

In relation to disposal and transfer, records were signed by two registered nurses. With the exception of the disposal of two Schedule 4 controlled drugs, the records indicated that controlled drugs were denatured prior to disposal. The registered manager clarified this with staff and we were assured that these had been denatured. Staff were reminded that this information should be recorded on every occasion.

A specific controlled drug record book had been brought into use in one unit. However, in another unit we noted that there were incomplete entries, some missing signatures and use of ditto marks in relation to administration. The controlled drug record book must be fully and accurately maintained. An area for improvement was made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the governance arrangements and quality improvement, the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

The administration process for controlled drugs must be reviewed to ensure records are fully and accurately completed.

	Regulations	Standards
Total number of areas for improvement	1	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Jacquelyn Woods, Registered 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 QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** First time	The registered person shall review the procedures for the administration of controlled drugs to ensure the controlled drug record book is fully and accurately completed. Ref: 6.3
To be completed by: 1 May 2019	**Response by registered person detailing the actions taken:** All Trained staff have been reminded of the importance of following the procedure for the administration of controlled drugs ,ensuring there are two signaturesto ensure the book is fully and accuratley completed . This is reviewed monthly as part of the Managers Medication audit

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

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