Announced Post-Registration Medicines Management Inspection Report
9 January 2018

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: Frances Gault

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 with 79 beds that provides care for patients as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Maryland Healthcare Limited **Responsible Individual:** Ms Susan McCurry	**Registered Manager:** Ms Jacquelyn Grace Woods
Person in charge at the time of inspection: Ms Jacquelyn Grace Woods	**Date manager registered:** 18 September 2017
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. LD – Learning disability. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** Total number 79 including: A maximum of 6 patients in category NH-LD to be accommodated in the Juniper Unit. A maximum of 33 patients in categories NH-I, NH-PH and NH-PH(E) to be accommodated between the Juniper and Willow Units. A maximum of 20 patients in category NH-DE to be accommodated in the Rowan Unit. A maximum of 20 patients in category NH-DE to be accommodated in the Larch Unit.

4.0 Inspection summary

An announced inspection took place on 9 January 2018 from 10.00 to 12.55.

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.

This was the first medicines management inspection since registration. It was an announced inspection in order to ensure that the registered manager was available. The inspection sought 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 systems that had been introduced.

An area requiring improvement was identified in relation to the maintenance of personal medication records and medicine administration records (MARs).

The patient spoken with advised that the care was “very good”.

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	1

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms 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 pre-registration inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 23 October 2017. Other than those actions detailed in the QIP no further actions were required to be taken. 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

During the inspection we met with one patient, the registered manager and two registered nurses.

A total of 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 poster informing visitors to the home that an inspection was being conducted was displayed.

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
- 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 23 October 2017

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

This was the first medicines management inspection to the home.

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. The registered manager advised that the impact of training will be monitored through team meetings, supervision and annual appraisal. Competency assessments were completed.

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.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses. This safe practice was acknowledged.

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

There were procedures in place to ensure the safe management of medicines during a patient's admission to, 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. Different types of records books were kept in the home and it was suggested that the same type should be used throughout. 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. insulin. 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 of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessments, the management of medicines on admission and controlled drugs.

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 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 recorded on the personal medication record were not specific. 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. Although a separate sheet was in place to record the reason for and the outcome of administration; this had not been completed in recent weeks. The registered manager agreed to remind the registered nurses of the expected practice.

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.

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 majority of medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the use of positional charts for transdermal patches and additional sheets for recording medicines which were administered when required.

Areas for improvement were identified in the personal medication records and MARs:

- registered nurses should not abbreviate dosage regimes when completing the MARs sheets
- the dose of insulin should be written as international units and not as "u"
- when the dosage or administration time is changed a new entry should be made on the MARs sheet
- entries on the personal medication records should identify if vitamin preparations or other supplements have been provided by relatives
- all additional entries to both the personal medication records and MARs sheets should be signed by two registered nurses

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines.

Following discussion with the registered manager and staff, it was evident that, when applicable, other healthcare professionals are contacted in response to the healthcare needs of the patients.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the administration of medicines.

Areas for improvement

Personal medication records and MARs must be accurately maintained.

	Regulations	Standards
Total number of areas for improvement	0	1

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 did not take place during this inspection.

Ten questionnaires were left in the home to facilitate feedback from patients and their representatives. None were received by the return date. 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.

One patient who was receiving intermediate care advised that he was satisfied that he received his pain relief medicines when requested.

Areas of good practice

There was evidence that staff listened to patients and relatives 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

Written policies and procedures for the management of medicines were in place. We had read these as part of the pre-registration process.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. A medicine related incident reported since the last medicines management inspection was discussed. There was evidence of the action taken and learning implemented following the incident.

A review of the audit records indicated that largely satisfactory outcomes had been achieved.

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. Care staff were not currently involved in any medicine related tasks.

Staff confirmed that any concerns in relation to medicines management were raised with management. The home had patients receiving intermediate care. As this had only begun recently a meeting with the trust was being held that afternoon to discuss progress. The staff and registered manager had identified a number of matters in relation to the management of medicines that they required to clarify.

Areas of good practice

There were examples of good practice found throughout the inspection 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 quality improvement plan (QIP). Details of the QIP were discussed with Ms 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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time	The registered person shall monitor the completion of the personal medication records and MARs to ensure that they are accurately maintained. Ref: 6.5
To be completed by: 9 February 2018	**Response by registered person detailing the actions taken:** The Registered person has a checking system in place to ensure the MAR sheets are accurately maintained.

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

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