Unannounced Medicines Management Inspection Report
12 December 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: 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 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 84 beds that provides care for patients living with healthcare 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 Clare McBride (Unit Manager)	**Date manager registered:** 18 September 2017
Categories of care: Nursing Homes (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: 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 unannounced inspection took place on 12 December 2018 from 10.20 to 17.15.

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 inspection assessed progress with any areas for improvement identified during and since the last medicines management inspection and 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 staff training and competency assessment, the administration of medicines and the security of medicines.

Areas for improvement were identified in relation to the standard of record keeping, care planning and audit.

The patients and relative we met with spoke positively about the staff and the care provided. There was a warm and welcoming atmosphere in the home and the patients were observed to be relaxed and comfortable in their environment.

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	*8

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Clare McBride, Unit Manager and Mrs Susan McCurry, Responsible Individual at the inspection, and Mrs Jacquelyn Woods, Registered Manager, by telephone on 17 December 2018, 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.

On 13 December 2018, the responsible individual provided us with a detailed action plan and a full account of the actions to be taken to ensure that robust systems for the management of medicines are in place.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 16 October 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 three patients, one relative, two registered nurses, one supervisor, the activities co-ordinator, the nurse in charge and the responsible individual.

A sample of the following records was examined during the inspection:

- medicines received
- personal medication records
- medicine administration records
- medicines disposed of
- controlled drug record books
- medicine audits
- care plans
- training records
- medicines storage temperatures

We provided 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA and we asked the unit manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

We left 'Have we missed you?' cards in the home to inform patients and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

Areas for improvement identified at the last medicines management inspection were reviewed and the 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 16 October 2018

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 post registration medicines management inspection dated 9 January 2018

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 29

Stated: First time</td><td>The registered person shall monitor the completion of the personal medication records and MARs to ensure that they are accurately maintained.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was limited evidence to indicate that an effective monitoring system for these records was in place. This area for improvement has been stated for a second time.</td></tr>
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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. Staff competency assessments were completed following induction, at least annually or more frequently as required. The impact of training was monitored through team meetings, supervision and annual appraisal. We were advised that further medicines management training was planned.

There were largely satisfactory procedures in place to ensure the safe management of medicines during a patient's admission to the home and for the management of medicine changes. Written confirmation of medicine regimes and any medicine changes were obtained. Personal medication records were updated by two trained staff. This is safe practice and was acknowledged. However, this did not occur for handwritten entries on medication administration records. This was discussed and an area for improvement identified.

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, report and follow up any potential shortfalls in medicines. We noted one medicine for use "as needed", was not in stock; staff assured that this had been ordered and expected delivery later on the day of the inspection.

Antibiotics and newly prescribed medicines had been received into the home without delay. We acknowledged that the written shift handover reports included reference to new medicines and medicine changes to ensure staff were kept up to date.

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

The management of controlled drugs was reviewed. Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book in each unit. The controlled drug record book in one unit did not include page numbers and it was suggested that a designated controlled drug record book should be obtained and brought into use. 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.

With the exception of Schedule 4 controlled drugs, discontinued or expired medicines were safely disposed of. In relation to the disposal/transfer of controlled drugs, staff should ensure that all Schedule 4 controlled drugs are denatured prior to disposal and a record of the disposal/transfer is recorded in the outgoing medicines record. An area for improvement was identified. This was discussed in relation to the organisation's Standard Operating Procedures for controlled drugs and the Care Standards for Nursing Homes.

The management of high risk medicines e.g. warfarin and insulin was reviewed. Separate administration records were in use, which is good practice. The benefit of recording the site of

administration of insulin was discussed. It was agreed that the dose of one patient's insulin would be clearly recorded on the patient's personal medication record and also care plan. In relation to warfarin, two staff should be involved in transcribing the new dosage regime on the records.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Each patient's medicines were clearly segregated. There were satisfactory systems to manage medicines which require cold storage and medicines with a limited shelf life once opened. Staff were advised that each patient's in use insulin pen device should be labelled. Oxygen equipment was checked on a regular basis.

A number of patients' medicines were supplied in seven day packs. These were not labelled to identify medicines regarding the shape, code and/or colour. All medicines must be readily identifiable for staff. An area for improvement was identified.

Areas of good practice

There were some examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and the safe storage of medicines.

Areas for improvement

Two staff should be involved in the transcribing of medicines details on all medication records.

The disposal and transfer of controlled drugs should be reviewed.

All medicines must be clearly identifiable.

	Regulations	Standards
Total number of areas for improvement	0	3

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. However, some discrepancies were identified; these were brought to the attention of staff/management who agreed to investigate and report to the prescriber as necessary. The need for an effective auditing process was discussed. See Section 6.7.

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 or three monthly medicines were due.

Some patients were prescribed medicines on a "when required" basis for the management of distressed reactions. We reviewed a sample of patient records. Detailed care plans regarding the parameters for administration were not in place and the reason for and outcome of the administration were not recorded. An area for improvement was identified. Staff were aware that distressed reactions may be the result of pain and that ongoing monitoring was necessary to ensure that the patient was comfortable.

The management of pain was reviewed. Medicine details were recorded on the personal medication records. Care plans and pain assessments were in place for some but not all patients

prescribed pain relieving medicines. An area for improvement was identified. Staff advised that most of the patients could tell staff if they were in pain; for those that couldn't they advised that they were familiar with how the patient would communicate any pain.

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. Care plans and speech and language assessment reports were in place. Systems were in place to ensure that staff were aware of patients' swallowing assessments. Records of administration were completed by registered nurses and care staff.

Staff advised 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 discussed with the patient/patient's family as necessary and reported to the patient's prescriber. We were provided with examples of when this had occurred to promote patient compliance.

In relation to the standard of record keeping, we found that several improvements were necessary. Some of the personal medication records did not include all of the necessary information and obsolete records required filing. There were missing signatures in the records of administration and staff advised that some of these were due to refusal by the patient, but this had not been recorded. We also noted occasions where staff had signed the administration record in error. The area for improvement identified at the last medicines management inspection has been stated for a second time.

There was limited evidence that robust systems were in place to maintain a record of all incoming medicines. These records must be fully maintained. Staff were advised that two staff should be involved in the disposal of medicines and both staff should sign the disposal record. An area for improvement was identified.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicines. The benefit of recording the quantity of medicine carried forward to the next medicine cycle to facilitate the audit process was discussed. A quarterly audit was also completed by the community pharmacist.

Following discussion with management and staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to patients' healthcare needs.

Areas of good practice

There were some examples of good practice in relation to the administration of medicines.

Areas for improvement

A record of the reason for and outcome of administration of medicines prescribed for distressed reactions should be maintained.

The care planning in relation to medicines management should be reviewed to ensure the care plans are reflective of the patient's needs.

Records of incoming and outgoing medicines must be fully and accurately maintained.

One area for improvement in relation to other medicine records has been stated for a second time.

	Regulations	Standards
Total number of areas for improvement	0	3

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 to patients was not observed during the inspection. Following discussion with staff it was evident they were knowledgeable about the patients' medicines and how the patients preferred to take their medicines.

Throughout the inspection, it was found that there were good relationships between the staff, the patients and the patients' representatives. Staff were noted to be friendly and courteous and engaged with the patients; they treated the patients with dignity. It was clear from observation of staff, that they were familiar with the patients' likes and dislikes.

We noted the warm and welcoming atmosphere in the home. Christmas decorations were displayed throughout the home. Some of the patients were taking part in activities.

We met with three patients who spoke positively about the care provided, the food and the staff. They stated that staff responded to any requests they had and advised they had no concerns. One patient provided details of the Christmas activities that she had completed. Other comments included:

- "The staff are brilliant; this is a great home."
- "I couldn't say anything bad at all."
- "The foods good, I get plenty and no complaints."
- "I'm doing well and getting better with the help of the staff."

We met with one relative who was complimentary regarding the staff, the care provided to her relative and their experience in the home.

Of the questionnaires which were left for patients/patients' representatives, four were returned within the specified time frame (two weeks). All of the responses were recorded as "very satisfied". The following comments were made:

- "First class care – very reassuring for family members - Willow Unit."
- "Very satisfied."
- "I'm looked after and treated very well; always someone there to help and talk to me and knowing whatever is discussed won't be passed on and if is wrong, management will come and sort it out."
- "Brilliant care! Fantastic staff – on first name basis with them all."

Areas of good practice

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.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. We were advised that there were arrangements in place to implement the collection of equality data.

The governance arrangements for medicines management were examined. There was evidence of the auditing and monitoring systems in place. This included daily, weekly and monthly audits. We were advised of how areas for improvement were shared with staff to address. However, as there were areas for improvement identified in the domains of safe and effective care, mainly regarding record keeping and care planning, and the area for improvement stated at the last medicines management inspection has been stated for a second time, the auditing system should be reviewed, to ensure it is effective in identifying shortfalls. An area for improvement was identified. It was suggested that the QIP forms part of the audit process to ensure sustained improvement. It was acknowledged that we were provided with a detailed action plan on 13 December 2018.

Written policies and procedures for the management of medicines were in place and readily available for staff reference. Staff advised that there were procedures in place to ensure that they were made aware of any changes.

There were satisfactory arrangements in place for the management of medicine related incidents. Staff knew how to identify and report incidents, including referral to the safeguarding team as necessary. They provided details of the procedures in place to ensure that all staff were made aware of incidents and systems to prevent recurrence.

We were advised that there were effective communication systems to ensure that all staff were kept up to date. Staff advised of the team meetings held and the handwritten shift handover reports; in relation to medicines, these reports included medicines prescribed for asthma, diabetes and swallowing difficulty. See also Section 6.4.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with management.

The staff spoke positively about their work and advised there were good working relationships in the home and with other healthcare professionals. They stated they felt well supported in their work and stated they had no concerns. They were complimentary regarding the management team and the training and opportunities provided.

No online questionnaires were completed by staff within the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to the management of incidents. There were clearly defined roles and responsibilities for staff.

Areas for improvement

The auditing process for medicines management should be reviewed to ensure that it is effective.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Clare McBride, Unit Manager, Mrs Susan McCurry, Responsible Individual, and 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 via the 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:** Second time **To be completed by:** 12 January 2019	The registered person shall monitor the completion of the personal medication records and MARs to ensure that they are accurately maintained. Ref: 6.2 & 6.4
	Response by registered person detailing the actions taken: Audit of MAR is completed weekly by Unit Managers and monthly by Director of Nursing
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 12 January 2019	The registered person shall ensure that the transcribing of medicines information is verified by two staff and both staff sign the record. Ref: 6.4
	Response by registered person detailing the actions taken: All Nurses have been informed about importance of two staff signatures , compliance for this is checked weekly and monthly
Area for improvement 3 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 12 January 2019	The registered person shall review the management of controlled drugs in relation to disposal and transfer. Ref: 6.4
	Response by registered person detailing the actions taken: Management of controlled drugs in relation to disposal and transfer has been reviewed and ammended
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 12 January 2019	The registered person shall ensure that all medicines are appropriately labelled. Ref: 6.4
	Response by registered person detailing the actions taken: Medications were reviewed and labelled accordingly
Area for improvement 5 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 12 January 2019	The registered person shall ensure that care plans are updated in relation to medicines management to reflect the patient's needs. Ref: 6.4 & 6.5
	Response by registered person detailing the actions taken: All care plans were reviewed and updated accordingly

Area for improvement 6 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 12 January 2019	The registered person shall ensure that the reason for and outcome of medicines administered for distressed reactions is recorded. Ref: 6.5
	Response by registered person detailing the actions taken: Distressed reaction forms are implemented and completed for reason of administration and outcome
Area for improvement 7 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 12 January 2019	The registered person shall ensure that records of all incoming and outgoing medicines are fully and accurately maintained. Ref: 6.5
	Response by registered person detailing the actions taken: Recordsof all incoming and outgoing medicines are audited weekly and monthly to ensure they are accuratley maintained
Area for improvement 8 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 12 January 2019	The registered person shall review the auditing systems to ensure that they are effective. Ref: 6.5 & 6.7
	Response by registered person detailing the actions taken: Audit has been reviewed and updated and are effective

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews