Unannounced Medicines Management Inspection Report
18 January 2017

Madelayne Court

Type of Service: Nursing Home
Address: 1-27 Nursery Avenue, Portstewart, BT55 7LG
Tel no: 028 7083 1014
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Madelayne Court took place on 18 January 2017 from 10.00 to 16.15.

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. There were no requirements or recommendations 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. Specific areas of medicines management were detailed in most of the patient's care records examined. However, three areas of improvement were identified in relation to external preparations, record keeping and care plans; one requirement and two 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. There were no requirements or recommendations 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. There were no requirements or recommendations 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.

For the purposes of this report, the term 'patients' will be used to described those living in Madelayne Court, which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	2

As part of the inspection process, details of the Quality Improvement Plan (QIP) within this report were discussed with the deputy manager, Miss Gemma Boyd; and also with the registered manager, Mrs Mabel Cole, by telephone on 19 January 2017. 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 5 December 2016.

2.0 Service details

Registered organisation/registered person: Runwood Homes Ltd Mr John Rafferty	**Registered manager:** Mrs Mabel Cole
Person in charge of the home at the time of inspection: Miss Gemma Boyd (Deputy Manager)	**Date manager registered:** 14 September 2015
Categories of care: RC-I, NH-PH(E), NH-MP(E), NH-I, NH-TI, NH-DE	**Number of registered places:** 66

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 reported to RQIA since the last medicines management inspection.

We met with two patients, one care staff, one registered nurse and the deputy 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.

Thirty questionnaires were issued to patients, relatives/patients' representatives and staff; with a request 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 5 December 2016

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 their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection 9 June 2015

There were no requirements of recommendations made as a result of the last medicines management inspection.

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. There was evidence that the community pharmacist had provided medicines management training for staff in the last year. Other training had been completed via the In Reach training programme which covered a variety of topics such as the management of dysphagia, syringe drivers, airway disease and skin care.

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.

Suitable procedures were in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two trained staff. This safe practice was acknowledged.

There were largely satisfactory arrangements in place to ensure the safe management of medicines during a patient's admission to the home and discharge from the home.

However, written confirmation of one new patient's medicine regime had not been obtained and it was agreed that the prescriber would be contacted to obtain this.

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. Staff were reminded that the brand name of the buprenorphine patches supplied, should be recorded.

There were satisfactory arrangements in place for the management of high risk medicines such as warfarin and insulin.

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 and tidy. It was noted that a number of nutritional supplements were stored on the floor in one treatment room, due to lack of shelf/cupboard space. This was discussed and should be reviewed. It was agreed that this would be addressed at the earliest opportunity.

Whilst there were systems in place to record the date of opening on medicines with a limited shelf life, two expired medicines were removed from stock and discussed with staff. There was no evidence that these had been recently administered. Medicine refrigerators and oxygen equipment were checked at regular intervals. Some oxygen cylinders were not secured to the wall. The deputy advised that this would be addressed later on the day of the inspection.

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?

Most of medicines examined had been administered in accordance with the prescriber's instructions. A few small discrepancies were observed and discussed.

There was evidence that time critical medicines had been administered at the correct time.

There were largely satisfactory arrangements in place to alert staff of when doses of alternate day, weekly, monthly or three monthly medicines were due. The majority of administration records had been marked out to indicate the day of administration. This is best practice. However, some audit trails on injectable medicines and external preparations could not be concluded. The registered manager stated that a separate chart for each injection would be implemented with immediate effect and that this would include a running stock balance. In relation to external preparations, see below.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were fully recorded on most of the personal medication records examined. A few required some further detail. 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 reason for and the outcome of administration were recorded. A care plan was maintained. There was also evidence that these medicines were included in the audit process.

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 a pain assessment was completed for all new patients. They stated that most of the patients could tell staff if they were in pain, and advised that in addition to their knowledge of the patient, a pain assessment tool was used for patients who could not verbally express pain. A pain management care plan was maintained.

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. Records of administration, 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.

Some of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate records detailing the administration and removal of transdermal patches. However, it was noted that some personal medication records were not up to date. Although a checking system was in place, this had not identified the areas to improve. A recommendation was made. In relation to external preparations, several were administered by designated care staff. The registered nurses signed to state that the care staff had administered these medicines; however, it was not clear if this delegated task had been checked and examination of the corresponding records completed by care staff did not always correlate with the other records. As a result it could not be ascertained if these medicines had been administered as prescribed. A requirement was made.

Largely satisfactory arrangements were in place for the management of self-administered medicines. Protocols signed by the patient were in place. A detailed care plan was maintained for one of the patients. A care plan should be maintained for any patient responsible for self-administration. A recommendation was made.

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

The staff spoken to at the inspection were very positive about their work and were very complimentary about the relationships between staff and the ongoing support provided by the staff team and the registered manager.

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 the health needs of the patients.

Areas for improvement

The systems in place to check the details on personal medication records should be reviewed, to ensure they are up to date. A recommendation was made.

The management of external preparations must be reviewed; these medicines must be administered as prescribed and the records must be fully and accurately maintained at all times. A requirement was made.

A detailed care plan should be maintained for any patient deemed competent to administer their medicines. A recommendation was made.

Number of requirements	1	Number of recommendations	2

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.

Throughout the inspection, it was evident that there were good relationships between the staff and the patients. The staff were kind, friendly and courteous to the patients.

The patients spoken to advised that they had no concerns regarding the management of their medicines and were complimentary regarding their care in the home. They advised that staff would respond in a timely manner to any requests they had.

Comments included:

"They are good to me."
"Staff couldn't look after me better".

One patient was heard to be expressing their content regarding the lunch that had been provided and had said "that was the loveliest meal, it's my favourite".

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As part of the inspection process questionnaires in relation to medicines management were issued to patients, relatives/patients' representatives and staff. Two questionnaires were completed and returned by relatives/patient representatives at the time of issuing the report. The responses were recorded as 'very satisfied' or 'satisfied' with the management of medicines in the home.

One relative's response detailed how the interaction by the staff had resulted in a positive outcome for a patient.

A system was in place to facilitate any patients who preferred to look after and administer their own medicines.

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. 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. They provided details of how incidents were shared with staff and how any learning was implemented.

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, registered nurses and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff advised that management were very approachable and willing to listen.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with through team meetings and a shift handover.

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 Miss Gemma Boyd, Deputy Manager and Mrs Mabel Cole 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 **RQIA's web portal** 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

Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 18 February 2017	The registered provider must ensure that there are robust arrangements in place for the management of external preparations.
	Response by registered provider detailing the actions taken: Staff have received training on administration of external preparations, and the importance of maintaining accurate records.We have implemented a more robust system whereby the Senior carer and the Nurse in charge of the unit checks and signs the records each day.
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 18 February 2017	The registered provider should make the necessary arrangements to ensure that personal medication records are up to date.
	Response by registered provider detailing the actions taken: A robust correlation system is in place and areas for improvement are identified and actioned.
Recommendation 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 18 February 2017	The registered provider should ensure that a detailed care plan is maintained for any patient responsible for the self-administration of their medicines.
	Response by registered provider detailing the actions taken: A detailed care plan is now implemented for Residents administering their own medications

Please ensure this document is completed in full and returned to RQIA's web portal

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