Unannounced Medicines Management Inspection Report
12 May 2017

Meadowbank

Type of Service: Nursing Home
Address: 11a Trench Road, Londonderry, BT47 2DT
Tel No: 028 7134 7281
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Meadowbank took place on 12 May 2017 from 10.40 to 13.55.

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. It was agreed that the management of new admissions and medication changes would be closely monitored and that registered nurses would receive supervision on the use of the refrigerator thermometer. No requirements or recommendations were made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. It was agreed that obsolete personal medication records would be cancelled and archived. No requirements or 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.

1.1 Inspection outcome

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mr Ryan O'Donnell, Acting Manager, and staff on duty, as part of the inspection process and can be found in the main body of the report.

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 June 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** See below
Person in charge of the home at the time of inspection: Mr Ryan O'Donnell, Acting Manager	**Date manager registered:** Mr Ryan O'Donnell, Acting – No Application Required
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 35

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 one patient, one relative, one care assistant, two registered nurses and the acting manager.

Fifteen questionnaires were issued to patients, relatives/representatives and staff, with a request that they were returned within one week from the date 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 June 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 21 April 2016

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

4.3 Is care safe?

The acting manager advised that all staff completed medicines management training via e-learning annually and that this training was up to date. Competency assessments and appraisals were currently being updated. Care staff received training on the application of emollient preparations and administration of thickening agents as part of their induction. Epilepsy awareness training was discussed and it was agreed that it would be reviewed and updated if necessary. Training on the management of syringe drivers was planned.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. There was evidence that antibiotics and newly prescribed medicines were received without delay.

The acting manager and registered nurses advised that safe systems were in place for the management of medicines during a patient's admission to the home and discharge from the home and the management of medication changes. However this was not observed for two patients. For one patient (receiving respite care) written confirmation of their medicines and an epilepsy management plan were not available. Their personal medication record and medication administration record had been verified and signed by two registered nurses and correlated with the medicines supplied by family. For a second patient the personal medication record and medication administration record had not been verified and signed by two members of staff, following a recent medication change. In addition the medication label had been amended. These findings were discussed with the acting manager and staff and corrective action was taken. The acting manager and registered nurse stated that this was not the usual practice. It was agreed that the management of medicines for new patients and medication changes would be closely monitored as part of the home's audit processes.

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.

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. Dates of opening had been recorded on the majority of medicines to facilitate audit and disposal at expiry. The maximum, minimum and current refrigerator temperatures were being recorded each day. However, some consistent readings were observed indicating that the thermometer was not being reset each day. Guidance on resetting the thermometer was provided for staff on duty. It was agreed that all registered nurses would receive supervision on accurately recording the refrigerator temperatures and resetting the thermometer.

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 majority of medicines examined had been administered in accordance with the prescriber's instructions; one discrepancy was discussed with the acting manager for close monitoring.

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. Care plans were in place. 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. These medicines had not been required recently. Staff on duty advised that the reason for and the outcome of administration were recorded when the medicines were used.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place. Staff advised that they 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 not verbalise their pain and that pain would be reviewed if there was any change in behaviour or if the patient seemed distressed.

The management of swallowing difficulty was examined. Care plans and speech and language assessments were in place. For those patients prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Each administration was recorded.

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. It was agreed that obsolete personal medication records would be cancelled and archived.

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 and inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the acting manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues. The majority of patients were registered with one GP practice; a GP from the practice visited the home each Friday.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

We did not observe medicines being administered.

Patients were observed to be relaxed and comfortable. Staff were engaging with patients in a caring way.

We spoke with one patient and a relative. Both were very happy with the care provided.

As part of the inspection process questionnaires were issued to patients, relatives/ representatives and staff, with a request that they were returned within one week from the date of the inspection. No responses were received within this timescale.

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. The acting manager was aware that medication related incidents may need to be reported to the safeguarding lead.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. The acting manager advised that any discrepancies would be investigated and learning/action plans would be discussed with staff.

Following discussion with the acting manager, registered nurses and care staff, 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. They advised that any resultant action was communicated to all staff either individually or at staff handovers.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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