Unannounced Medicines Management Inspection Report
2 February 2018

Woodmount

Type of Service: Nursing Home
Address: 15 Melmount Road, Strabane, BT82 9ED
Tel no: 028 7188 4234
Inspector: Helen Daly

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 servicefrom 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 homewith 32 beds that provides care for patients with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Woodmount **Responsible Individuals:** Mr Alfred Lindsay Woods	**Registered Manager:** Mrs Amanda Craig
Person in charge at the time of inspection: Mrs Amanda Craig	**Date manager registered:** 8 April 2016
Categories of care: Nursing Homes (NH): 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	**Number of registered places:** 32

4.0 Inspection summary

An unannounced inspection took place on 2 February 2018 from 10.35 to 14.45.

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 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 medicines administration, medicine records and the management of controlled drugs.

Areas requiring improvement were identified in relation to the management of medicines on admission.

Patients and relatives were complimentary regarding the care provided in the home.

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.

4.1Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	0

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Amanda Craig, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcementaction did not result from the findings of this inspection.

4.2Action/enforcementtaken following the most recent financeinspection

Other than those actions detailed in the QIPno further actions were required to be taken following the most recent inspection on 14 September 2017. 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 incidents register; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

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

During the inspectionwe met with one patient, one relative, two care assistants, two registered nurses, the registered manager and a general practitioner.

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 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

The findings of the inspection were provided to the person in charge at the conclusion of theinspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 14 September 2017

The most recent inspection of the home was an unannounced finance inspection.The completed QIP was returned and approved by the finance inspector.

This QIP will be validated by the finance inspector at the next finance inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 23 January 2017

There were no areas for improvement identifiedas a result of the last medicines managementinspection.

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.

The registered manager confirmed that medicines were managed by staff who have been trained and deemed competent to do so. Training on the management of medicines was provided annually be the community pharmacist. Competency assessments were completed annually. Refresher training on thickening agents, syringe drivers and enteral feeding had been provided in the last year. Training on the regional procedures for safeguarding had been completed within the last year.

Systems were in place to manage the ordering of prescribed medicines to ensure patients had a continuous supply. There was evidence that 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. The majority of personal medication records and handwritten entries on medication administration records were updated by two registered nurses. Registered nurses were reminded that the month and year of administration should be recorded on hand-written medication administration records.

We reviewed the management of medicines on admission for two patients. For one patient, although written confirmation of currently prescribed medicines had been obtained, the personal medication record was written from the labels of the medicines which were supplied by family. The medicines had not been recorded as received into the home and anomalies had not been followed up. For the second patient a discrepancy in the administration of one

medicine was observed. There must be robust procedures in place to ensure the safe management of medicines during a patient's admission to the home. An area for improvement was identified.

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. The registered manager was reminded that records of the disposal of controlled drugs should besigned and verified by two staff in the controlled drug record book. It was acknowledged that the record had been double signed in the disposal book.

Robust arrangements were observed for the management of high risk medicines e.g. insulin. The use of a separate administration chart 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. Dates of opening were recorded to facilitate audit and disposal at expiry. The refrigerator and treatment room temperatures were monitored daily; they were observed to be within the accepted range.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines changes and controlled drugs.

Areas for improvement

Robust systems should be in place for the management of medicines on admission.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

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

With the exception of one medicine (See Section 6.4) the sample of medicines examined had been administered in accordance with the prescriber's instructions.

There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

The management of distressed reactions, pain and swallowing difficulty was reviewed. The relevant information was recorded in the patients' personal medication records and records of administrations. Two care plans were required to be updated. The registered manager advised that this would be completed immediately after the inspection and that it would be kept under review. Due to the assurances provided an area for improvement was not identified.

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.

Arrangements were in place for auditing medicines management. Nursing staff audit two patient's medicines each night and these are then reviewed by the registered manager. Running stock balances were maintained for analgesics and nutritional supplements. A quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in patient care.

Areas of good practice

There were examples of good practice in relation to the standard of record keepingand the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

We observed the administration of medicines to two patients after lunch. The registered nurse administering the medicines spoke to the patients in a kind and caring manner and the patients were given time to swallow their medicines.

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

The patient spoken to at the inspection, advised that they had no concerns in relation to the management of their medicines, they preferred the registered nurses to administer their medicines and their requests for medicines prescribed on a 'when required' basis were adhered to e.g. pain relief. They were complimentary regarding staff and management. Comments included:

- "The staff are great. I enjoy the company. I didn't want to be home alone."

The relative we spoke to confirmed that he was very happy with the care provided for their family member. They advised that “staff could not be better”.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As part of the inspection process, we issued 10 questionnaires to patients and their representatives. Four patients completed and returned questionnaires within the specified timeframe. Comments received were positive; with responses recorded as ‘very satisfied’ or ‘satisfied’ with the care provided in the home.

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.

Written policies and procedures for the management of medicines were in place. The registered manager advised that they were reviewed and updated at least every three years.

The registered manager advised that there were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents.In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the audit records indicated that largely satisfactory outcomes had been achieved.The registered manager confirmed that action plans from the community pharmacist audits were implemented without delay.

Following discussion with the registered manager, registered nurses and care assistants, 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 management were open and approachable and willing to listen.

The staff spoken to during the inspection were complimentary about the management of the home. One recently recruited care assistantsaid that coming to work in the home was “the best move I’ve ever made.”

Areas of good practice

There were examples of good practice in relation to governance arrangements 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 QIP. Details of theQIP were discussed with Mrs Amanda Craig, 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 standardsthis 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 improvementidentified 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 providershould confirm that these actions have been completed and return the completed via theWeb 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 **To be completed by:** 2 March 2018	The registered person shall ensure that safe systems are in place for the management of medicines on admission to the home. Ref: 6.4
	Response by registered persondetailing the actions taken: There has now been implemented a audit for new patient medications, to be completed by the staff nurse on the day of admission. The manager has then also to complete a audit one week later to ensure safe systems are in place for medicatins of new admissions.

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

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