Unannounced Medicines Management Inspection Report
8 January 2019

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 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 that provides care for up to 32 patients with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Woodmount **Responsible Individual:** 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 8 January 2019 from 10.20 to 14.40.

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

One area for improvement in relation to records for the management of distressed reactions was identified.

We spoke with two patients who were complimentary regarding the care and staff 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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

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.

Enforcement action did not result from the findings of this inspection.

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 27 July 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 home was reviewed. This included the following:

- recent inspection reports
- 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

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

During the inspection the inspector met with two patients, one care assistant, two registered nurses and the registered manager.

We provided staff with 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. We left 'Have we missed you?' cards in the home to inform patients/their representatives, how to contact RQIA to tell us of their experience of the quality of care provided. Flyers providing details of how to raise concerns were also left in the home.

We asked staff to display a poster which invited staff to share their views and opinions 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
- care plans
- training records
- medicines storage temperatures

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 27 July 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP 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 dated 2 February 2018

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation **13 (4)** **Stated:** First time	The registered person shall ensure that safe systems are in place for the management of medicines on admission to the home.	**Met**
	Action taken as confirmed during the inspection: We reviewed the management of medicines on admission/re-admission for two patients. Written confirmation of current medication regimens had been received. The personal medication records had been written/updated by one registered nurse and verified by a second registered nurse. The records of medicines received into the home had been accurately maintained.	

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 registered nurses who have been trained and deemed competent to do so. Training was provided annually by the community pharmacist. Records were

available for inspection. Competency assessments were also completed annually or more frequently if a need was identified. Care assistants had received training and been deemed competent to administer thickening agents.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training had been provided in August and September 2018.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and to manage medication changes. Personal medication records and hand-written entries on the medication administration records were verified and signed by two registered nurses. This safe practice was acknowledged.

There were systems in place to ensure that patients had a continuous supply of their prescribed medicines. There was evidence that antibiotics and newly prescribed medicines had been received into the home without delay.

Robust arrangements were observed for the management of high risk medicines e.g. insulin. The use of separate administration charts was acknowledged. Dates of opening were recorded on all insulin pens to facilitate audit and disposal at expiry.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Stock balance checks were performed on controlled drugs which require safe custody at the end of each shift.

Satisfactory arrangements were in place for the safe disposal of discontinued or expired medicines.

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. Satisfactory recordings were observed for the treatment room and refrigerator temperatures.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, 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 majority of medicines examined had been administered in accordance with the prescriber's instructions. A small number of discrepancies were discussed with the registered manager for on-going monitoring. 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, monthly or three monthly 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 were recorded on the personal medication record. 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. Detailed care plans were in place. The time of administration and reason for and the outcome of administration were not routinely being recorded. An area for improvement was identified.

The management of pain and swallowing difficulty was reviewed and satisfactory systems were observed. Detailed care plans were in place. Records of prescribing and administration were maintained.

Registered nurses 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 reported to the prescriber for review.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the separate recording sheets for analgesics and antibiotics.

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

Following discussion with the registered manager and registered nurses, 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 keeping, care planning and the administration of medicines.

Areas for improvement

The registered person shall review the management of medicines prescribed for administration on a "when required" basis for the management of distressed reactions. The time of administration and reason for and outcome of administration should be recorded.

	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.

We did not observe the administration of medicines to any patients during the inspection. Discussion with the registered nurses indicated that they were familiar with the patients' medicines and how they liked to take them.

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. Patients were observed to be relaxed and comfortable. Staff were discussing the television programmes with patients throughout the morning. One patient was celebrating a birthday; staff and visitors were creating a jovial atmosphere.

We spoke with two patients who were complimentary regarding the care provided and staff in the home. Comments included:

- "The staff are very good to you."
- "The food is very good. You can have what you want."

As part of the inspection process 10 questionnaires were issued to patients and their representatives. All were returned during the inspection. Responses indicated that patients and their representatives were "satisfied" or "very satisfied" with the care provided.

Areas of good practice

Staff were observed to listen to patients, engage them in conversation and to take 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 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. Arrangements were in place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. They were not reviewed at the inspection.

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

The governance arrangements for medicines management were examined. Management advised of the daily auditing processes completed by staff and reviewed by the registered manager. Areas identified for improvement were detailed in an action plan which was shared with staff to address and there were systems in place to monitor improvement.

Following discussion with the registered nurses and care assistant, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They advised that any concerns in relation to medicines management were raised with the registered manager.

The staff we met with spoke positively about their work and advised there were good working relationships in the home with staff and the registered manager. They stated they felt well supported in their work.

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 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 the QIP 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 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 18 **Stated:** First time **To be completed by:** 8 February 2019	The registered person shall review the management of medicines prescribed for administration on a “when required” basis for the management of distressed reactions. The time of administration and reason for and outcome of administration should be recorded. Ref: 6.5
	Response by registered person detailing the actions taken: All staff Nurses informed for the need to record “when required” basis for the management of distressed reactions medications, the time of administration, reason for and outcome, on both the mars sheet and the daily progress notes.

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

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