

Unannounced Medicines Management Inspection Report 23 January 2017



Woodmount

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

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Woodmount took place on 23 January 2017 from 10:35 to 14:15.

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. No areas for improvement were identified.

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. No areas for improvement were identified.

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 areas for improvement were identified.

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 areas for improvement were identified.

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 Mrs Amanda Craig, Registered Manager, 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 13 September 2016.

2.0 Service details

Registered organisation/registered person: Woodmount Mr Alfred Lindsay Woods & Mrs Roberta Jillian Woods	Registered manager: Mrs Amanda Craig
Person in charge of the home at the time of inspection: Mrs Amanda Craig	Date manager registered: 8 April 2016
Categories of care: NH-I, NH-PH, NH-PH(E)	Number of registered places: 32

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 five patients, two care staff, the registered manager, two registered nurses, and one patient's relative.

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.

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 13 September 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and was 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 dated 23 November 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 Ref: Regulation 13(4) Stated: First time	The registered person must ensure that records of the administration of thickening agents and medicines for external use by care staff are maintained.	Met
	Action taken as confirmed during the inspection: Records of the administration of thickening agents by care staff were being maintained. Care staff are no longer responsible for administering medicines for external use.	
Requirement 2 Ref: Regulation 13(4) Stated: First time	The registered person must ensure that there are robust arrangements in place to audit all aspects of the management of medicines.	Met
	Action taken as confirmed during the inspection: Robust arrangements were in place for auditing medicines. Nursing staff audit two patient's medicines each night and the manager audits medicines management on a monthly basis. Records showed that the community pharmacist completed a medicines audit in the home every three months.	

<p>Requirement 3</p> <p>Ref: Regulation 13(4)</p> <p>Stated: First time</p>	<p>The registered person must put robust systems in place to ensure medicines are being stored at the correct temperature.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>The temperature of medicine storage areas and the medicines refrigerator has been monitored and recorded on a daily basis. Records of the temperature of the treatment room and the medicines refrigerators indicated that medicines have been stored at the correct temperature.</p>		
<p>Last medicines management inspection recommendations</p>		<p>Validation of compliance</p>
<p>Recommendation 1</p> <p>Ref: Standard 28</p> <p>Stated: First time</p>	<p>Additional monitoring and auditing arrangements for insulin should be implemented.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>Additional arrangements have been implemented. Separate prescription records for insulin and separate records of the administration of insulin were in place and these have been checked and verified by two registered nurses.</p>		
<p>Recommendation 2</p> <p>Ref: Standard 28</p> <p>Stated: First time</p>	<p>A copy of the waste transfer note for the disposal of medicines should be kept in the home.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>Waste disposal records were maintained in the home and these were reviewed during the inspection.</p>		
<p>Recommendation 3</p> <p>Ref: Standard 28</p> <p>Stated: First time</p>	<p>Written policies and procedures should cover each of the activities associated with the management of medicines (including controlled drugs), they should be subject to regular review and update and there should be evidence that staff have read the policies and procedures.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>Comprehensive written policies and procedures for the management of medicines were in place and there was evidence that these had been reviewed and updated in 2016. Staff had signed to indicate they had read the policies.</p>		

Recommendation 4 Ref: Standard 18 Stated: First time	The management of medicines prescribed on a “when required” basis for distressed reactions should be reviewed and revised to ensure individual care plans are in place and staff record why a medicine was required to be administered and the noted effect.	Met
	Action taken as confirmed during the inspection: Individual care plans were in place and the majority of records of administration indicated why the medicine was required to be administered and its effect.	
Recommendation 5 Ref: Standard 28 Stated: First time	The management of pain should be assessed on admission, care plans should be in place for those patients prescribed regular pain relief and there should be evidence that appropriate pain tools are used to assess pain where necessary.	Met
	Action taken as confirmed during the inspection: There was evidence that the management of pain has been reviewed and revised. Pain has been assessed on admission, care plans were in place and pain assessment tools have been used to assess pain where necessary.	
Recommendation 6 Ref: Standard 28 Stated: First time	Authorisation should be obtained from the prescriber for the administration of any licensed medicines outside the terms of the product licence, e.g. administration through a PEG tube.	Met
	Action taken as confirmed during the inspection: Authorisation was obtained following the last inspection. There were no patients with a PEG tube in the home on the day of this 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. Refresher training in medicines management was provided in the last year. The most recent training was in relation to the management of swallowing difficulties, the management of palliative care, the management of syringe drivers and the completion of care plans.

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.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

There were procedures in place to ensure the safe management of medicines during a patient’s admission to the home.

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.

Robust arrangements were observed for the management of high risk medicines e.g. insulin. The use of separate administration charts 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. 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.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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4.4 Is care effective?

The sample of medicines examined had been administered in accordance with the prescriber’s instructions. There was evidence that time critical medicines had been administered at the correct time.

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. The reason for and the outcome of administration were recorded on most occasions. A care plan was maintained.

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 most of the patients could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment is completed as part of the admission process.

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. Each administration was recorded and 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.

Medicine records were generally well maintained and facilitated the audit process.

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 nutritional supplements. In addition, 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 are contacted in response to the healthcare needs of patients.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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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.

Patients spoken to advised that they had received their medicines that day, that they were happy with the way their medicines were managed and that they could request medication for pain if required.

We spoke to one relative who advised they were satisfied with the care provided and would contact the registered manager of the home or the Trust care manager if there were any areas or issues of concern.

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.

Ten staff questionnaires, five relative/visitor questionnaires and ten questionnaires for patients were forwarded to the home to facilitate feedback. Six staff questionnaires were returned during the inspection and all respondents stated they were very satisfied with the way medicines were managed in the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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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. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents.

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.

The requirements and recommendations made at the last medicines management inspection had been addressed. The improvements noted in the management of medicines since the last inspection were noted and acknowledged.

Staff confirmed that any concerns in relation to medicines management were raised with management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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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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