Unannounced Medicines Management Inspection Report
4 December 2017

Weavers House

Type of Service: Nursing Home
Address: 40 Moneymore Road, Cookstown, BT80 8EH
Tel No: 028 8676 7684
Inspector: Judith Taylor

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 with 65 beds that provides care for patients and residents with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Mr Gavin O'Hare-Connolly	**Registered Manager:** Mrs Brenda Rushe
Person in charge at the time of inspection: Mrs Brenda Rushe	**Date manager registered:** 16 January 2015
Categories of care: Nursing Homes (NH) DE – Dementia Residential Care Home (RC) DE – Dementia I – Old age not falling within any other category PH(E) - Physical disability other than sensory impairment – over 65 years PH – Physical disability other than sensory impairment	**Number of registered places:** 65 comprising: NH-DE – 30 RC –DE – 24 RC-PH, RC-PH(E), RC-I – maximum of 11

4.0 Inspection summary

An unannounced inspection took place on 4 December 2017 from 10.25 to 15.40.

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 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 the governance arrangements for medicines, training, the standard of record keeping, the administration of medicines and management of controlled drugs.

An area requiring improvement was identified in relation to care plans for the management of distressed reactions.

Patients spoke positively about the management of their medicines and the care provided by the staff. There was a warm and welcoming atmosphere 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.

For the purposes of this report, the term 'patients' will be used to describe those living in Weavers House which at this time provides both nursing and residential care.

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 Brenda Rushe, 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 19 August 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 management of medicine related incidents 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 we met with three patients, one registered nurse, two senior care staff and the registered manager.

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

A total of 10 questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completion of an online questionnaire.

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 19 August 2017

The most recent inspection of the home was an unannounced follow-up care inspection. The completed QIP was returned and 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 24 November 2016

There were no areas for improvement identified as a result of the last medicines management inspection.

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 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. An ongoing programme of training was in place.

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. 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 procedures in place to ensure the safe management of medicines during a patient's admission to the home and to manage changes to prescribed medicines.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

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.

Robust arrangements were observed for the safe management of high risk medicines e.g. warfarin. Care plans were in place.

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 of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessment, the management of medicines on admission/medicine changes 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.

With the exception of a few medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. The administrations of those medicines which should be closely monitored were highlighted to staff and management. The registered manager gave an assurance that these would be monitored from the day of the inspection onwards.

On occasion some medicines were required to be crushed prior to administration or administered in disguised form. This was recorded in the patient's care plan. Consent had been obtained from the prescriber.

There were satisfactory arrangements in place to alert staff of when time critical medicines must be administered, such as early morning medicines and also medicines which were prescribed at weekly, twice weekly, fortnightly and three monthly intervals.

The management of distressed reactions was reviewed. When a patient was prescribed a medicine for administration on a "when required" basis the dosage instructions were recorded on the personal medication record. Staff confirmed that they 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 the administration was recorded. The outcome should also be recorded. Care plans were not in place for the patients whose records were examined at the inspection. An area for improvement was identified.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. A care plan was maintained. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff advised that some of the patients could tell staff if they were experiencing pain, and confirmed that a pain assessment tool was used as needed. Staff also advised that a pain assessment was 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.

When an antibiotic was prescribed, a care plan was maintained. This is good practice.

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. They confirmed that most patients were generally compliant with their medicine regimes.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the maintenance of separate administration records for transdermal patches, injectable medicines, analgesics and high risk medicines; and double signatures for the writing and updating of personal medication records and medication administration records.

Practices for the management of medicines were audited on a daily and weekly basis by the staff. This included running stock balances for medicines which were not supplied in the monitored dosage system. Staff routinely recorded the stock balance of medicines carried forward to the next medicine cycle. These records readily facilitated the audit process and this good practice was acknowledged. A quarterly audit was also completed by the community pharmacist.

Following discussion with the registered manager and staff and a review of care files, it was evident that when applicable, other healthcare professionals are contacted in response to patients' healthcare needs.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the administration of medicines, the standard of record keeping. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

A care plan should be maintained for each patient prescribed medicine to manage distressed reactions and the outcome of each 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.

There were systems in place to accommodate any patients who preferred to self-administer their medicines. A care plan was in place and was monitored on a monthly basis.

We observed the administration of a small number of medicines. Staff spoke to 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.

We noted the warm and welcoming atmosphere in the home. Christmas decorations were displayed throughout the home and Christmas music was playing in the background.

The patients we met with spoke positively about their care and the management of their medicines. They were noted to be content in their room or enjoying the music in the lounge. They were complimentary regarding staff and management. Comments included:

"Staff are very good here."
"If I need anything, they get me it."
"I have no pain now, but I can get tablets if I need them."
"They are good."
"The food is nice, I have no complaints."

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.

We met with staff throughout the inspection. Comments included:

"We have a good team, we are like a family."
"I enjoy my job."
"There is support from everyone."
"This is a good place to work."

Although we had left questionnaires for patients and their representatives and invited staff to complete an online questionnaire, no questionnaires were completed or returned to RQIA at the time of issuing this report.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing patients and taking account of the views of patients.

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. These were not examined in detail. Staff advised that they were familiar with them and were kept up to date of any changes.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents and advised of how incidents were shared with them to inform learning and change of practice, if necessary. We were advised that incidents and audit outcomes were also discussed as part of the quality meetings which were held every month. 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 robust governance process to oversee medicines management was in place. Daily audit reports were reviewed by management. These reports readily identified any areas for improvement and there was evidence that issues were reported and addressed in a timely manner.

Following discussion with the registered manager and staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

There were effective communications systems in the home to ensure that all staff were kept up to date. The shift handovers were verbal and written and a sample of the written handover sheet was observed. The registered manager advised that a meeting was also held every morning with the unit managers/head of departments in the home. In relation to medicines management, this meeting was used to inform staff of new admissions, discharges, medicine changes, dietary requirements, audits and incidents as required.

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. They also stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of medicine incidents, quality improvement and maintaining good working relationships.

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 Brenda Rushe, 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 QIP via 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	The registered person shall review the management of distressed reactions to ensure that a care plan is maintained and the outcome of administration is recorded on each occasion. Ref: 6.5
To be completed by: 4 January 2018	**Response by registered person detailing the actions taken:** Manager has ensured all residents that receive medication for distressed reactions have an appropriate care plan for this. Manager discussed at quality meeting the recording of outcomes from administration of distressed reactions and recording this on each occasion. The manager shall monitor this.

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

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