Unannounced Medicines Management Inspection Report
26 July 2018

Weavers House Nursing Home

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 18 beds that provides care for patients living with dementia. It is situated on the same site as Weavers House Residential Care Home.

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	**Number of registered places:** 18

4.0 Inspection summary

An unannounced inspection took place on 26 July 2018 from 14.30 to 17.40.

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 the governance arrangements for medicines, training and competency assessment, medicine administration, medicines storage and the standard of record keeping.

No areas for improvement were identified.

Patients said they were happy in the home and spoke positively about the management of their medicines and the care provided by staff. We noted the 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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Brenda Rushe, Registered Manager and Ms Kathleen Henry, Deputy 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.

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 follow up care inspection on 11 May 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 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 was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

During the inspection we met with two patients, two staff, the deputy manager and the registered manager.

We provided ten 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 and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

We asked the deputy manager 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
- policies and procedures
- 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 11 May 2018

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 the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 4 December 2017

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 18

Stated: First time</td><td>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.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There were no patients prescribed medicines for the management of distressed reactions at the time of this inspection. Management advised that this had been addressed following the last medicines management inspection; if prescribed, we were advised that a care plan would be maintained and evaluated at least monthly; and details regarding any administration would be recorded.

Given these assurances this area for improvement has been assessed as met.</td></tr>
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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 also for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings and supervision. Competency assessments were completed following induction, as part of the incident management process and at least annually. Staff appraisals were completed annually. There were systems in place to ensure that staff were up to date in medicines management training.

The management of new patients' medicines and medicines changes was examined. There were satisfactory arrangements in place. Written confirmation of medicine regimes and medicine changes was obtained. Two staff were involved in updating the personal medication records and medication administration records. This is safe practice.

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.

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

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.

There were robust arrangements in place for the safe disposal of medicines, including controlled drugs.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. The medicine refrigerator and oxygen equipment were checked at regular intervals.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. The administration of one eye preparation was discussed. Occasionally, the records indicated that this was not required; however, it should be administered daily. This was investigated by management immediately after the inspection and they provided details of the corrective action taken on 27 July 2018.

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 or three monthly medicines were due.

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 some of the patients could verbalise pain, and a pain assessment tool was used as needed. A care plan was maintained. 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. 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 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 some medicines which were not supplied in the 28 day blister packs.

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

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

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.

The medicines were administered in a kind and caring manner. The registered nurse gave the patient time to take their medicines and explained the medicines.

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

We met with two patients. They were noted to be relaxed and comfortable in their environment. They advised that they were happy to be in the home and that they had no concerns. Comments included:

"It's alright here; I'm getting on ok. I have nothing to complain about."
"It's very nice here; the staff are good."
"I have no problems with the food."
"The garden is lovely."

Some of the patients were observed to be sitting outside enjoying the weather.

Of the questionnaires which were distributed, three were returned from patients/patients representatives. The responses indicated that they were very satisfied/satisfied with the care provided in the home. One comment regarding staffing levels was made and this was shared with the registered manager for her attention and also with the care inspector. One other comment was made:

"Most staff are excellent, kind, compassionate and care for xxx (relative). Thank you."

Any further comments in questionnaires received after the return date (two weeks) will be shared with the registered manager for information as necessary.

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.

The inspector 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. We were advised that arrangements were in place to implement the collection of equality data within Weavers House Nursing Home.

Written policies and procedures for the management of medicines were in place. A record to indicate that staff had read and understood them was maintained. Staff advised that they were kept up to date regarding any changes.

The governance arrangements for medicines management were reviewed. Management advised of the daily, weekly and monthly audits which take place and how areas for improvement were identified and followed up. This was usually through the development of action plans and staff supervision. A sample of the audit outcomes was provided. Also, as part of the pharmacist support to the home, a quarterly audit was undertaken and a list of the findings was left in the home for management to address.

There were satisfactory arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. They provided details of the procedures in place to ensure that all staff were made aware of incidents and to prevent recurrence. These usually included reflective practice and supervision. We discussed the medicine related incidents reported and the resultant changes in practice which had occurred. 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.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with the registered manager; and any resultant action was discussed at team meetings and/or supervision. They spoke positively about their work and advised that there were good working relationships in the home with staff, management and with other healthcare professionals. They stated they felt well supported in their work.

The communication systems were reviewed. Staff advised that the shift handovers were verbal and written. The registered manager stated that she completed a walk around each unit every morning and used the outcomes of the written handover report to ensure any issues were addressed. She 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.

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, the management of medicine incidents 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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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