Unannounced Medicines Management Inspection Report
24 November 2016

Weavers House

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

1.0 Summary

An unannounced inspection of Weavers House took place on 24 November 2016 from to 10.00 to 16.25.

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. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues has enabled the systems in place for the management of medicines to be robust. No requirements or recommendations were made.

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. Care plans regarding specific areas of medicine management were in place. No requirements or recommendations were made.

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 requirements or recommendations were made.

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. There were no areas for improvement 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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

For the purposes of this report, the term ‘patients’ will be used to described those living in Weavers House which provides both nursing and residential care.

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 Brenda Rushe, 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 11 October 2016.

2.0 Service details

Registered organisation/registered person: Runwood Homes Ltd/ Mr John Rafferty	**Registered manager:** Mrs Brenda Rushe
Person in charge of the home at the time of inspection: Mrs Brenda Rushe	**Date manager registered:** 16 January 2015
Categories of care: NH-DE, RC-PH(E), RC-PH, RC-I, RC-DE	**Number of registered places:** 65

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 three patients, three members of senior care staff, two registered nurses and the registered manager.

Twenty-five questionnaires were issued to patients, relatives/patients' representatives and staff, with a request that these were returned within one week of the inspection.

The following records were 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 11 October 2016

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 their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 23 June 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must develop a robust audit process for the management of medicines.	**Met**
	Action taken as confirmed during the inspection: A robust audit process was evidenced at the inspection.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must implement effective systems to ensure that personal medication records are fully and accurately maintained at all times.	**Met**
	Action taken as confirmed during the inspection: There was evidence that most of the personal medication records examined had been well-maintained. A new audit system for checking personal medication records has been recently developed and was planned to be implemented this month.	

Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must ensure that the records of administered medicines are fully and accurately maintained on each occasion. **Action taken as confirmed during the inspection**: The records were generally well maintained and included reasons for omissions.	**Met**
Requirement 4 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must put robust arrangements in place for the management of blood glucometers. **Action taken as confirmed during the inspection**: There were robust arrangements in place for the management of blood glucometers.	**Met**
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 18 **Stated:** First time	It is recommended that the registered person should ensure that where medicines are prescribed on a "when required" basis for the treatment of distressed reactions, a care plan is in place and staff record the reason for and the outcome of the administration of the medicine on every occasion. **Action taken as confirmed during the inspection**: The sample of records examined indicated that a care plan was maintained for the majority of the patients who were administered these medicines. The reason for and outcome of administration was recorded on some occasions. The registered manager confirmed by email on 25 November 2016 that all of the care plans were now in place, that all staff had received information regarding record keeping and that this would be closely monitored. Given the assurances provided by the registered manager this recommendation was assessed as met.	**Met**

Recommendation 2 **Ref**: Standard 4 **Stated:** First time	It is recommended that the registered person should ensure that where medicines are prescribed for the management of pain, this is clearly referenced in a care plan.	**Met**
	Action taken as confirmed during the inspection: The management of pain was detailed in a care plan.	

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, agency staff 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 October 2016. Other training in the management of distressed reactions and pain management was provided in April 2016.

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 and discharge from 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.

Appropriate arrangements were in place for administering medicines in disguised form.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. Staff were reminded that the disposal record should clearly state that the controlled drugs have been denatured.

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 usually systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. However, one in-use insulin pen did not state the date of opening. Three discontinued eye preparations were removed for disposal at the inspection. These issues were being addressed by the staff during the inspection.

Satisfactory arrangements were in place for the management of medicines which require cold storage, blood glucometers and oxygen.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

The majority of medicines examined had been administered in accordance with the prescriber's instructions. One large discrepancy in a liquid medicine was noted and discussed. The registered manager provided assurances that this medicine would be closely monitored.

There was evidence that time critical medicines had been administered at the correct time. There were largely satisfactory arrangements in place to alert staff of when doses of weekly or three monthly medicines were due. Reminder alerts were in place on the administration records and also a separate list was maintained.

A staff communication book was maintained and viewed at each shift change. This included information regarding medicines and the outcomes of visits from/consultation with other healthcare professionals.

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 some but not all occasions. A care plan was maintained for most of patients administered these medicines. The registered manager provided assurances that these issues were addressed immediately after the inspection.

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. The good practice of maintaining a pain chart for the administration of analgesics was acknowledged. This detailed the reason for pain relief. 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.

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. Areas of good practice were acknowledged. They included separate administration records for injectable medicines including insulin, transdermal patches and bisphosphonate medicines.

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 medicines management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.5 Is care compassionate?

Appropriate arrangements were in place to facilitate patients responsible for the self-administration of medicines.

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. Medicines were dispensed from their container, immediately prior to administration.

Patients were noted to be enjoying the music activities which were being undertaken at the time of the inspection. There was evidence of good relationships with staff.

The patients spoken to advised that they had no concerns regarding the management of their medicines. They were very complimentary about their care in the home and about the staff. Some comments included:

"very good in here"
"the staff are good"
"food is lovely"
"am settled well"

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.

As part of the inspection process, questionnaires were issued to patients, relatives/ patients' representatives and staff. Seven patients, nine staff and two relatives/patient's representatives completed and returned these within the specified timescale. All of the responses were recorded as 'very satisfied' or 'satisfied' with medicines management in the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

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.

In relation to the management of dementia, the registered manager advised that all grades of staff were involved in a dementia project which was near to completion. She advised that this involved staff being trained on how the patient experiences dementia with particular focus on the management of distressed reactions and pain management. The involvement in initiatives like this indicated that this service was seeking to make positive changes to benefit patients and included all members of the staff team to implement these changes.

It was noted that staff were very knowledgeable regarding the individual patient needs with respect to medicines.

An improved auditing process for medicines management had been developed since the last medicines management inspection and there was evidence that this had been well embedded into routine practice. Practices for the management of medicines were audited throughout the month by the registered manager, registered nurses and senior care staff. The audits included running stock balances for several solid dosage medicines, liquid medicines and inhaled medicines and review of medicine records and medicine equipment. In addition, a quarterly audit was completed by the community pharmacist.

The audit process was readily facilitated by recording the date of opening on medicines and also recording the quantity of medicine carried forward from the last medicine cycle. 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.

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.

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.

Staff advised that management were open and approachable and willing to listen. They stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

It was observed that there were effective communication systems in place. As well as written handover reports, verbal handovers were completed at the end of each shift. In addition, a daily head of department meeting was held, which included a representative from the nursing units, residential units, housekeeping and maintenance departments. In relation to medicines management, this meeting was used to inform staff of new admissions, discharges, changes in medicines, dietary requirements, audit discrepancies and incidents.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated to staff on an individual basis and at supervision.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

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.

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews