Unannounced Medicines Management Inspection Report
13 February 2017

The Graan Abbey

Type of Service: Nursing Home
Address: Derrygonnelly Road, Enniskillen, BT74 5PB
Tel no: 028 6632 7000
Inspector: Helen Mulligan

1.0 Summary

An unannounced inspection of The Graan Abbey took place on 13 February 2017 from 10:30 to 15:20.

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. Improvements are necessary in the management of medicines during admission. A copy of current prescriptions should be kept in the home. One requirement and one recommendation 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. One area for improvement was identified in relation to the management of distressed reactions. A recommendation was made for the second time.

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. There were no areas for improvement 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. 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.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Pamela Fee, Registered Manager and Ms Wendy Shannon, Quality and Governance Lead, 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.

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 9 February 2017.

2.0 Service details

Registered organisation/registered person: Carewell Homes Ltd Mrs Carol Kelly	**Registered manager:** Ms Pamela Fee
Person in charge of the home at the time of inspection: Ms Pamela Fee	**Date manager registered:** 21 September 2016
Categories of care: RC-DE, RC-A, NH-PH, NH-MP, NH-MP(E), NH-LD, NH-I, RC-I, RC-PH, NH-DE, RC-MP, RC-MP(E)	**Number of registered places:** 86

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 four residents, five members of staff, and one patient's visitor/representative.

Samples of 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 9 February 2017

The most recent inspection of the home was an unannounced care inspection. The report of this care inspection has not yet been issued to the home.

4.2 Review of requirements and recommendations from the last medicines management inspection 1 March 2016

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 18 **Stated:** First time	Details of the administration of medicines prescribed on a "when required" basis for the management of distressed reactions, including the reason for and noted outcome of administration, should be recorded in the patient's daily notes on each occasion.	**Not met**
	Action taken as confirmed during the inspection: The reason for and noted outcome of administration of medicines for the management of distressed reactions was not recorded on every occasion. This recommendation has been stated for the second time.	
Recommendation 2 **Ref**: Standard 4 **Stated:** First time	The management of pain should be reviewed and revised to ensure care plans are complete and an appropriate pain tool/scale is used where applicable.	**Met**
	Action taken as confirmed during the inspection: Care plans for the management of pain were in place and there was evidence that an appropriate pain assessment tool/scale had been used where necessary.	

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 topical medicines.

A small number of out of stock medicines, including paracetamol were noted. Staff were reminded that robust systems must be in place to manage and prevent shortfalls in medicines. A copy of current prescriptions was not kept in the home and this should be addressed. A recommendation was made.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were verified and signed by two designated members of staff. This safe practice was acknowledged.

The management of medicines during a patient's admission was reviewed for one patient recently admitted to the home. The procedures were not robust and this must be addressed. Discrepancies were noted between the current medication list supplied by the prescriber and the medicines received; there was no evidence that staff in the home had contacted the prescriber to verify the patient's current prescription. Insufficient medicines were received on admission and, as a result, the patient's medicines were out of stock for one day. Staff were reminded that medicines received in monitored dosage cassettes should be identifiable and records should detail the individual medicines received and administered. Robust arrangements must be in place to ensure the safe management of medicines during admission. A requirement was made. Following the inspection, the registered manager confirmed by telephone on 14 February 2017 that the prescriber had been contacted and the current medicines had been verified.

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. warfarin and insulin. The use of separate administration charts was acknowledged.

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.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. 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. Staff were reminded that all oxygen cylinders should be chained to the wall when not in use.

Areas for improvement

A copy of current prescriptions should be kept in the home. A recommendation was made.

Robust arrangements must be in place for the management of medicines during admission. A requirement was made.

Number of requirements	1	Number of recommendations	1

4.4 Is care effective?

The sample of medicines examined indicated that they had been administered in accordance with the prescriber's instructions. Staff were reminded that any discrepancies between the personal medication record and the medicine label should be brought to the attention of the prescriber and/or pharmacist for verification of the correct prescription details.

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. A care plan was maintained. The reason for and the outcome of administration were not always recorded and this should be addressed. A recommendation made at the previous medicines management inspection was stated for the second time.

The management of pain was reviewed for one patient. 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.

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

Details of the administration of medicines prescribed on a "when required" basis for the management of distressed reactions, including the reason for and noted outcome of administration, should be recorded in the patient's daily notes on each occasion.
A recommendation was stated for the second time.

Number of requirements	0	Number of recommendations	1

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:

"I'm happy here"
"The food is good"
"I got my medicines"

One relative advised she was "very happy with my husband's care".

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 left in the home to facilitate feedback. At the time of writing, seven questionnaires had been received from members of staff who reported that they were either satisfied or very satisfied with the management of medicines 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. These had all been comprehensively reviewed and updated in 2016. 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.

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.

One of the recommendations made at the last medicines management inspection had not been addressed effectively. To ensure that all recommendations are fully addressed and any improvements are sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Pamela Fee, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and the Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to pharmacists@rqia.org.uk for assessment by the inspector.

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. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 15 March 2017	The registered provider must ensure that robust arrangements are in place for the management of medicines on admission.
	Response by registered provider detailing the actions taken: The Medicine Policy has been reviewed and addendum in respect of medicine management on admission of a resident has been added to policy. Registered nurse meeting held on 21/2/17 and communicated to nurses the findings of pharmacy inspection; minutes of meeting distributed to all registered nurses. It was highlighted to nurses that they must carefully check the current medication list from GP against medication received and to follow up on any medications that don't tally up. It was also highlighted that sufficient medicines must be received on admission so that patient's supply does not run out. Nurses reminded that medicines received in 'blister packs' should be identifiable and records should show each individual medicine received and administered. This will be monitored and kept under review by registered manager.
Recommendations	
Recommendation 1 **Ref**: Standard 18 **Stated:** Second time **To be completed by:** 15 March 2017	Details of the administration of medicines prescribed on a “when required” basis for the management of distressed reactions, including the reason for and noted outcome of administration, should be recorded in the patient’s daily notes on each occasion.
	Response by registered provider detailing the actions taken: At registered nurse meeting on 21/2/17 all nurses again reminded that the reason for and outcome of administration of medication for management of distressed reactions should be fully recorded in daily notes on each occasion. Registered nurses adviced to always consider pain as a possible factor and to ensure effective pain management. This will be monitored and reviewed by registered manager.
Recommendation 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 15 March 2017	The registered provider should ensure a copy of current prescriptions is kept in the home.
	Response by registered provider detailing the actions taken: All registered nurses adviced of this recommendation at meeting on 21/2/17. Files for keeping copies of current prescriptions for each patient have now been commenced in the three units within the Home. This will be monitored and kept under review by registered manager.

The Regulation and Quality Improvement Authority

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