Unannounced Medicines Management Inspection Report
12 January 2017

Movilla House

Type of Service: Nursing Home
Address: 51 Movilla Road, Newtownards, BT23 8RG
Tel No: 028 9181 9399
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Movilla House took place on 12 January 2017 from 10.10 to 15.35.

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. However three areas for improvement in relation to the disposal of controlled drugs, the crushing of medicines and the maintenance of medication administration records were identified. Two requirements 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. 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. No requirements or recommendations were made.

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. RQIA will continue to monitor any recommendations made under the 2008 standards until compliance is achieved.

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

1.1 Inspection outcome

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Tracey Anderson, 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.

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 27 September 2016.

2.0 Service details

Registered organisation/registered person: Movilla House Ltd Mr Derek Alfred Bell	**Registered manager:** Mrs Tracey Anderson
Person in charge of the home at the time of inspection: Mrs Tracey Anderson	**Date manager registered:** 19 September 2016
Categories of care: RC-I, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 50

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 one patient, two care assistants, two registered nurses and the registered manager.

A number of questionnaires were issued to patients, relatives/representatives and staff, with a request that they were returned within one week from the date of the inspection.

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. No one availed of this opportunity during the inspection.

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 27 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.

At the care inspection the evening medication round had commenced at 15.30. The registered manager confirmed that this had not been usual practice and that it had been reviewed with all the nursing staff.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 26 August 2014

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 37 **Stated:** First time	Standard Operating Procedures should be developed for the management of controlled drugs.	**Met**
	Action taken as confirmed during the inspection: Standard Operating Procedures for the management of controlled drugs were in place. Copies were available in each treatment room.	

Recommendation 2 **Ref:** Standard 37 **Stated:** First time	The recording system in place for all patients who are prescribed 'when required' anxiolytic and antipsychotic medicines should include detailed care plans and the documentation of the reason for and outcome of administration in the daily progress notes.	**Partially Met**
	Action taken as confirmed during the inspection: Care plans were in place for patients who were prescribed these medicines. One needed to be updated. The reason for and outcome of each administration had been recorded on some but not all occasions. Specific sheets to record this information were in place. The registered manager advised that this would be discussed with all registered nurses and included in the home's audit system. Due to the assurances provided this recommendation has not been stated for a second time.	
Recommendation 3 **Ref:** Standard 37 and 38 **Stated:** First time	Two registered nurses should witness medicines being placed in the medicines disposal bin and should sign the disposal record.	**Met**
	Action taken as confirmed during the inspection: The records of disposal indicate that two registered nurses were involved in the process.	
Recommendation 4 **Ref:** Standard 39 **Stated:** First time	A lock should be fitted to each medicine refrigerator.	**Met**
	Action taken as confirmed during the inspection: Locks were in place on both medicine refrigerators.	
Recommendation 5 **Ref:** Standard 39 **Stated:** First time	The temperatures of medicine storage areas should be monitored regularly and recorded.	**Met**
	Action taken as confirmed during the inspection: The room temperatures were being monitored and recorded in each treatment room daily.	

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 supervision and annual appraisal. Competency assessments were completed annually.

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.

Improvements in the arrangements in place to manage changes to prescribed medicines were necessary. It was acknowledged that the majority of updates on the personal medication records had been verified and signed by two registered nurses. However, several handwritten entries on medication administration records had not been verified and signed by two registered nurses. In addition one entry had been amended rather than cancelled and a new entry made; it was acknowledged that this was not usual practice. The registered provider should ensure that hand-written entries on the medication administration records are signed and verified by two registered nurses. A recommendation was made.

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. However, as detailed above not all hand-written entries on the medication administration records had been verified and signed by two registered nurses.

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 management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged.

One medicine was being crushed prior to administration. This medicine should not normally be crushed and this had not been authorised by the prescriber or the suitability checked with the community pharmacist. The registered provider must ensure that robust systems are in place when medicines are being crushed prior to administration. A requirement was made.

The majority of discontinued or expired medicines were disposed of appropriately. However, discontinued controlled drugs in Schedule 4 (Part 1) had not been denatured and rendered irretrievable prior to their disposal. The registered provider must ensure that controlled drugs in Schedule 4 (Part 1) are denatured and rendered irretrievable prior to their disposal. A requirement was made. It was agreed that the Standard Operating Procedures would be updated to reflect this practice.

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

The registered provider must ensure that robust systems are in place when medicines are being crushed prior to administration. A requirement was made.

The registered provider must ensure that discontinued controlled drugs in Schedules 4 (Part 1) are denatured and rendered irretrievable prior to their disposal. A requirement was made.

The registered provider should ensure that hand-written entries on the medication administration records are signed and verified by two registered nurses. A recommendation was made.

Number of requirements	2	Number of recommendations	1

4.4 Is care effective?

The sample of medicines examined had been administered in accordance with the prescriber's instructions; some small discrepancies were discussed with the registered manager. 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, monthly or three monthly medicines were due.

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. Care plans were in place though some needed to be updated. An email confirming that all care plans were up to date was received by RQIA on 17 January 2017. 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. Sheets were in place to enable registered nurses to record the reason for and the outcome of administration; however these had not been completed on all occasions. The registered manager advised that this would be discussed with all registered nurses and monitored closely. Due to these assurances this recommendation was not stated for a second time.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Pain assessment tools were in use. Staff confirmed that pain assessments were 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. Care plans and speech and language assessments were in place. Registered nurses recorded administration on the medication administration records. Care assistants recorded administration on a computerised system.

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.

The majority of records were well maintained. However some improvements were necessary in the standard of maintenance of the personal medication records and medication administration records.

Personal medication records should be up to date and reflect the prescribers' most recent directions. The date of writing should be recorded and obsolete personal medication records should be cancelled and archived. When eye preparations are prescribed, the directions must indicate which eye(s). These improvements were discussed with the registered manager and registered nurses. A recommendation was not made as the majority of the personal medication records were satisfactory.

As detailed in Section 4.3 two registered nurses should verify and sign all hand-written updates on the medication administration records. A small number of missed signatures for administration were observed; this was discussed for corrective action.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for medicines which were not included in the blister pack system.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

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?

The registered manager advised that where possible patients would be encouraged to self-administer their medication. The need to maintain detailed care plans and to record the receipt and transfer of the medicines to the patients for self-administration was discussed. These care plans and recording systems were commenced during the inspection.

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.

We spoke with one patient who advised that she was "content, which was much more than happy living in Movilla House and that she would recommend it to anyone."

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 20 questionnaires were issued to patients, relatives/representatives and staff, with a request that they were returned within one week from the date of the inspection. Five members of staff and one relative completed and returned the questionnaires. The responses were positive and these were recorded as "satisfied" or "very satisfied" with regard to 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 available in both treatment rooms. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff. It was agreed that the Standard Operating Procedure for the disposal of controlled drugs would be updated.

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. The registered manager and registered nurses advised that if a discrepancy was identified it would be investigated and an action plan to prevent a recurrence would be put in place. Some of these action plans were observed during the inspection.

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 recommendation which was made at the last medicines management inspection had not been fully addressed. To ensure that these are fully addressed and the improvement 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. They advised that any resultant action was communicated with registered nurses either individually or via staff meetings.

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 Mrs Tracey Anderson, 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 taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return 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:** 12 February 2017	The registered provider must ensure that robust systems are in place when medicines are being crushed prior to administration.
	Response by registered provider detailing the actions taken: The medication in question has been changed to metformin (not SR) and is no longer being crushed at all. All nurses have been informed of the policy and procedures surrounding crushing medications - in that medications must only be crushed following a discussion with the pharmacist and GP that it is safe to do so and that a letter of authorization is in place signed by the GP. Staff have subsequently signed that they have read and understood the policy
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 12 February 2017	The registered provider must ensure that discontinued controlled drugs in Schedules 4 (Part 1) are denatured and rendered irretrievable prior to their disposal.
	Response by registered provider detailing the actions taken: SOP for disposal of and denaturing of controlled drugs has been updated, signs have been put into both clinical rooms about the denaturing of the above drugs. All nurses have been informed of updated policy
Recommendations	
Recommendation 1 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 12 February 2017	The registered provider should ensure that hand-written entries on the medication administration records are signed and verified by two registered nurses.
	Response by registered provider detailing the actions taken: All nurses are fully aware that this needs completed. I have reinforced this with all staff and will be checking weekly that it has been completed as advised

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address

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

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