The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report
13 December 2017

Movilla House

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

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 50 beds that provides care for patients with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Movilla House Ltd Responsible Individual: Mr Derek Alfred Bell	Registered Manager: Mrs Tracey Anderson
Person in charge at the time of inspection: Mr Graeme Jellie, Registered Nurse	**Date manager registered:** 19 September 2016
Categories of care: Nursing Home (NH) I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years TI – terminally ill	**Number of registered places:** 50

4.0 Inspection summary

An unannounced inspection took place on 13 December 2017 from 10:10 to 14:20.

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 medicines administration, the management of controlled drugs and care planning.

Areas requiring improvement were identified in relation to the storage of medicines and the standard of maintenance of the personal medication records.

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	1	1

Details of the Quality Improvement Plan (QIP) were discussed with Mr Graeme Jellie, Registered Nurse, and Mrs Tracey Anderson, Registered Manager, via telephone call on 19 December 2017, 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 6 September 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 one patient, one care assistant and three registered nurses.

Ten questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views 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 6 September 2017

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 12 January 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 Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 13 (4)

Stated: First time</td><td>The registered provider must ensure that robust systems are in place when medicines are being crushed prior to administration.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The registered manager advised that robust systems were put in place following the last medicines management inspection.

Medicines were not currently being crushed prior to administration.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Regulation 13 (4)

Stated: First time</td><td>The registered provider must ensure that discontinued controlled drugs in Schedules 4 (Part 1) are denatured and rendered irretrievable prior to their disposal.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Discontinued controlled drugs in Schedules 4 (Part 1) were being denatured and rendered irretrievable prior to their disposal.</td></tr>
</table>

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		Validation of compliance
Area for improvement 1 **Ref:** Standard 29 **Stated:** First time	The registered provider should ensure that hand-written entries on the medication administration records are signed and verified by two registered nurses.	**Met**
	Action taken as confirmed during the inspection: The majority of hand-written entries on the medication administration records were observed to be signed and verified by two registered nurses.	

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.

The registered manager confirmed that medicines were managed by staff who have been trained and deemed competent to do so. Registered nurses completed update training on medicines management via e-learning each year. Competency assessments were completed annually. Care assistants had received training and been deemed competent to administer emollient preparations and thickening agents.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. However, on the day of the inspection two medicines were out of stock for one patient resulting in two and four missed doses of each medicine. Registered nurses had contacted the surgery and the medicines were due on the day of the inspection; the registered manager confirmed that the medicines had been received. 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 mostly satisfactory arrangements in place to manage changes to prescribed medicines. However a number of the personal medication records had not been updated on the first floor; an area for improvement regarding record keeping was made in Section 6.5.

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged. The registered nurses were reminded that obsolete warfarin dosage directions should be cancelled and archived.

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. The medicines room on the ground floor was clean, tidy and well organised. However, the medicines room on the first floor was cluttered and untidy. The sink area was not clean. An area for improvement was identified. 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 in relation to staff training, competency assessment, the management of medicines on admission and controlled drugs.

Areas for improvement

The medicines room on the first floor should be thoroughly cleaned and maintained to an acceptable level of cleanliness.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

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

The majority of medicines examined had been administered in accordance with the prescriber's instructions. A small number of discrepancies were discussed with the registered nurses for follow up.

The management of distressed reactions, swallowing difficulty and pain was reviewed. The relevant information was recorded in the patients' care plans, personal medication records and records of administrations.

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.

Improvements in the standard of maintenance of the personal medication records were necessary. These records must be up to date and form an integral part of the medication administration round. Some personal medication records were not up to date. Obsolete records had not been cancelled and archived. An area for improvement was identified.

Practices for the management of medicines were audited throughout the month by the staff and management. In addition, audits were completed by the community pharmacist. Running stock balances were being maintained for several medicines; some of these balances were incorrect and this was discussed with one of the registered nurses and the registered manager for review.

Following discussion with the registered manager and staff, it was evident that other healthcare professionals are contacted when required to meet the needs of patients.

Areas of good practice

There were examples of good practice in relation to care planning and the administration of medicines.

Areas for improvement

The personal medication records should be up to date and reflect the prescribers' most recent directions. The layout of the medicines file should be reviewed to ensure that safe systems are in place.

	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.

We observed the administration of medicines to a small number of patients at lunchtime. The registered nurse administering the medicines spoke to the 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.

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, we issued ten questionnaires to patients and their representatives; none were returned within the specified timeframe.

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.

Written policies and procedures for the management of medicines were in place; they were not examined at the inspection.

There were robust arrangements in place for the management of medicine related incidents. Medicine related incidents reported since the last medicines management inspection had been managed appropriately. In relation to the regional safeguarding procedures, the registered manager confirmed that staff were aware that medicine incidents may need to be reported to the safeguarding team.

The registered manager had recently completed an audit on the management of medicines. An action plan to address the identified shortfalls was in place.

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

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.

One member of staff shared their views by completing an online questionnaire. Comments received were positive; with responses recorded as ‘satisfied’ with the care in the home.

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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mr Graeme Jellie, Registered Nurse, and Mrs Tracey Andrews, Registered Manager, via telephone, 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 via the Web Portal for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 27.2 (d) **Stated:** First time **To be completed by:** 13 January 2018	The registered person shall ensure that the medicines room on the first floor is thoroughly cleaned and maintained to an acceptable level of cleanliness. Ref: Section 6.4
	Response by registered person detailing the actions taken: The first floor treatment room has been redecorated, sink has been replaced and all nurses have been advised to not leave used medication cups in the sink. The treatment room is and always has been cleaned thoroughly on a daily basis by the domestic staff. The manager has been intermittently reviewing the cleanliness of the treatment room to ensure standards are maintained daily
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 29 **Stated:** First time **To be completed by:** 13 January 2018	The personal medication records should be up to date and reflect the prescribers' most recent directions. Ref: Section 6.5
	Response by registered person detailing the actions taken: All nursing staff have been advised that Personal Medication Records need to be kept up to date, with date medication received/discontinued documented, all personal medication records have been reviewed with supplementary documentation not in use being filed away in a timely manner. The manager will review medication audits to ensure standards are maintained

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

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