Unannounced Medicines Management Inspection Report
12 May 2016

Mullaghboy

86 Warren Road, Donaghadee, BT21 0PQ
Tel No: 028 9188 3596
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Mullaghboy took place on 12 May 2016 from 09:30 to 13:10.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern though one area for improvement was identified and is set out in the quality improvement plan (QIP) within this report.

Is care safe?

No requirements or recommendations have been made.

Is care effective?

One recommendation has been stated for the second time.

Is care compassionate?

No requirements or recommendations have been made.

Is the service well led?

No requirements or recommendations have been 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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the QIP within this report were discussed with Ms Anne Dugan, 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 inspection on 26 April 2016.

2.0 Service details

Registered organisation/registered person: Mullaghboy Limited/ Mr Robert Maxwell Duncan	**Registered manager:** Mrs Anne Dugan
Person in charge of the home at the time of inspection: Mrs Anne Dugan	**Date manager registered:** 1 April 2005'.
Categories of care: NH-I ,NH-PH ,NH-PH(E) ,NH-TI	**Number of registered places:** 32

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.

Prior to the inspection, it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with two residents, the registered manager and two registered nurses.

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 26 April 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be reviewed by the care inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 7 September 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 29 **Stated:** First time	It is recommended that the patient's medicine allergy status should be routinely declared on their personal medication record sheet.	**Partially Met**
	Action taken as confirmed during the inspection: The patient's medicine allergy status had not been declared on some personal medication record sheets. **This recommendation was restated**	
Recommendation 2 **Ref**: Standard 29 **Stated:** First time	It is recommended that running stock balances should be maintained for warfarin preparations.	**Met**
	Action taken as confirmed during the inspection: Running stock balances had been maintained for warfarin preparations.	

Recommendation 3 **Ref**: Standard 18 **Stated:** First time	It is recommended that, if medication is prescribed on a "when required" basis for the management of distressed reactions, the care plan should identify the parameters for its administration and the reasons for administration and the outcome should be recorded.	**Met**
	Action taken as confirmed during the inspection: Where medication was prescribed on a "when required" basis for the management of distressed reactions, the care plan identified the parameters for its administration. No patients had recently been administered medication on a "when required" basis for this purpose; however, the registered manager confirmed that, when administered, the reason for administration and the outcome were recorded.	

4.3 Is care safe?

Medicines were managed by staff who had 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.

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 were generally signed by the general medical practitioner.

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. The use of separate administration charts for warfarin was acknowledged.

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 manufacturers' 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

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

The sample of medicines examined had been administered in accordance with the prescriber's instructions. 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 three monthly injectable medicines were due.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the parameters for administration were recorded on the personal medication record. A care plan was maintained. No patients had recently been administered medication on a "when required" basis for this purpose. 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 sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff advised that a pain assessment was completed as part of the admission process. A pain tool was completed and updated as necessary. A care plan was maintained and it was evaluated on a monthly basis. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record. Care plans and speech and language assessment reports were in place. Administrations were not recorded; the registered manager provided an assurance that this matter would be rectified.

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. A couple of medicines were not recorded on the personal medication record sheets; the registered manager provided an assurance that this matter would be rectified. The patient's medicine allergy status had not been declared on some personal medication record sheets; a recommendation was restated.

Practices for the management of medicines were audited throughout the month by management. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff and a review of care files, it was evident that, when applicable, other healthcare professionals were contacted in response to issues or concerns in relation to medicines management.

Areas for improvement

The patient's medicine allergy status should be routinely declared on their personal medication record sheet. A recommendation was stated for the second time.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

The morning medication round had been completed before the commencement of the inspection. No medicines were observed to be administered to patients during the inspection.

The patients spoken to advised that they had no concerns in relation to the management of their medicines, and their requests for medicines prescribed on a "when required" basis was adhered to e.g. pain relief.

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.

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 them by management.

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 internal audit records indicated that satisfactory outcomes had been achieved.

Following discussion with the registered manager and staff, 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.

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

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

The issue identified during this inspection is detailed in the QIP. Details of this QIP were discussed with Mrs Anne Dugan, Registered Manager, as part of the inspection process. The timescale commences from the date of inspection.

The registered person/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 person/manager 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 your premises. 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 person/s 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 DHSSPS Care Standards for Nursing Homes (2015). They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to pharmacists@rqia.org.uk and assessed 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 person/manager 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 person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** Second time **To be completed by:** 11 June 2016	It is recommended that the patient's medicine allergy status should be routinely declared on their personal medication record sheet.
	Response by registered person detailing the actions taken: Allergy status has now been updated on personal medication record sheets. Nurses have been reminded to maintain.

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

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