# Unannounced Medicines Management Inspection Report
# 2 November 2016

# The Martin Residential Trust

**Type of Service: Nursing Home**
**Address: 48 Ballyclare Road, Glengormley, BT36 5HL**
**Tel no: 028 9034 2365**
**Inspector: Judith Taylor**

## 1.0 Summary

An unannounced inspection of The Martin Residential Trust took place on 2 November 2016 from 10.55 to 14.35.

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. 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 enables 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 generally supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Two areas for improvement were identified in relation to care plans and record keeping; two 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. There were no areas of 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. 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.

## 1.1 Inspection outcome

| | Requirements | Recommendations |
|---|---|---|
| **Total number of requirements and recommendations made at this inspection** | 0 | 2 |

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Penny McCanny, 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 14 September 2016.

## 2.0 Service details

| | |
|---|---|
| **Registered organisation/registered person:**<br>The Martin Residential Trust/<br>Rev James Smiley Martin | **Registered manager:**<br>Mrs Penny McCanny |
| **Person in charge of the home at the time of inspection:**<br>Mrs Penny McCanny | **Date manager registered:**<br>1 April 2005 |
| **Categories of care:**<br>NH-LD, NH-LD(E) | **Number of registered places:**<br>19 |

## 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 two patients, two registered nurses and the registered manager.

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 14 September 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 8 July 2014

| **Last medicines management inspection statutory requirements** | | **Validation of compliance** |
|---|---|---|
| **Requirement 1**<br><br>**Ref:** Regulation 13 (4)<br><br>**Stated:** First time | The registered manager must ensure that controlled drugs are denatured by two registered nurses prior to disposal. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Staff confirmed that controlled drugs were denatured prior to disposal. This process was clearly recorded in the policies and procedures. Staff were reminded that the disposal record should clearly indicate that the medicine has been denatured. | |
| **Last medicines management inspection recommendations** | | **Validation of compliance** |
| **Recommendation 1**<br><br>**Ref:** Standard 37<br><br>**Stated:** First time | The registered manager should ensure that two designated staff sign the record of the disposal of medicines on each occasion. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Two registered nurses were involved in the disposal of medicines and each nurse's signature was recorded. | |

| | | |
|---|---|---|
| **Recommendation 2**<br><br>**Ref:** Standard 38<br><br>**Stated:** First time | The registered manager should ensure that two designated staff sign new entries on personal medication records and handwritten entries on medication administration record sheets. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The majority of handwritten medicine entries on personal medication records and medication administration records had been signed by two registered nurses. The registered manager advised that this was the expected practice and staff would be reminded to ensure this occurs on each occasion. | |

## 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. There was a programme of training which included the management of epilepsy, dysphagia and enteral feeding. The most recent training in medicines management had been provided in August 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 usually 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 when on periods of temporary leave from the home.

Discontinued or expired medicines were disposed of appropriately. Staff confirmed that discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. This was not recorded on the disposal record and it was agreed that this would be recorded from the day of the inspection onwards.

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**

No areas for improvement were identified during the inspection.

| | | | |
|---|---|---|---|
| **Number of requirements** | 0 | **Number of recommendations** | 0 |

## 4.4 Is care effective?

The outcomes of the audit trails performed on a variety of randomly selected medicines indicated that medicines had been administered in accordance with the prescriber's instructions.

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 would not be able to verbalise if they were in pain. A pain assessment tool was not in use; however, the registered manager advised that the staff had been employed in the home for several years and were aware of how a patient would express pain. This was further discussed and this information should be recorded in a care plan. A recommendation was made.

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. A care plan and records of administration were maintained. A speech and language assessment report was in place. There was evidence that staff had read and signed that they understood these reports.

Some medicines were added to food to aid swallowing. The registered manager advised that the suitability of this procedure had been confirmed with the prescriber and that she was waiting for written confirmation. This information should be recorded in the resident's care plan. A recommendation was made.

The management of fluid intake regarding enteral feeding was examined. The fluid intake charts were generally well maintained and included the total 24 hour intake. However, the records did not include the volume of enteral feed. On further review it was concluded that the prescribed volume of fluid intake was being achieved. The registered manager advised that this would be raised with staff and implemented with immediate effect.

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.

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, nutritional supplements and liquid medicines. In addition, a quarterly audit was completed by a representative from the community pharmacy.

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

**Areas for improvement**

The management of pain should be reviewed to ensure that details of how this would be expressed by the patient and managed by the staff are referenced in a care plan. A recommendation was made.

In the instances where medicines are required to be added to food to aid swallowing, details of the procedures should be clearly referenced in the patient's care plan. A recommendation was made.

| Number of requirements | 0 | Number of recommendations | 2 |
|---|---|---|---|

## 4.5 Is care compassionate?

The administration of medicines was not observed at the time of this inspection. Following discussion with staff it was ascertained that medicines were administered to patients in a timely manner and the patients were given time to swallow their medicines.

We met with two patients who came into the office and from their interactions it was clear that the patients were relaxed and comfortable in their surroundings.

Staff were observed to be caring and patients were treated with dignity and respect. It was evident that there were good relationships 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. These had been reviewed in June 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 system was in place to implement learning following incidents.

A review of the internal 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.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated through the communication book, at shift handover or individually with staff.

**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 Penny McCanny, 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 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 or 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 | |
|---|---|
| **Recommendations** | |
| **Recommendation 1**<br><br>**Ref**: Standard 4<br><br>**Stated:** First time<br><br>**To be completed by:**<br>2 December 2016 | The registered provider should review the management of pain to ensure that this is clearly referenced in a care plan. |
| | **Response by registered provider detailing the actions taken:**<br>A pain assessment tool is now in use, with an individualised nursing need intervention in each care plan. |
| **Recommendation 2**<br><br>**Ref**: Standard 29<br><br>**Stated:** First time<br><br>**To be completed by:**<br>2 December 2016 | The registered provider should ensure that where medicines are added to food to aid swallowing, this is referenced in care plan. |
| | **Response by registered provider detailing the actions taken:**<br>The nursing care plans of those residents who take medicines with food in order to aid swallowing have been updated to include this information. |

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

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