Unannounced Medicines Management Inspection Report
2 October 2017

Queenscourt

Type of Service: Nursing Home
Address: 36 Doagh Road, Ballyclare, BT39 9BG
Tel No: 028 9334 1472
Inspector: Judith Taylor

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 43 beds that provides care for patients living with learning disability.

3.0 Service details

Organisation/Registered Provider: Manor Healthcare Ltd **Responsible Individual:** Mr Eoghain King	**Registered Manager:** See box below
Person in charge at the time of inspection: Ms Sharon Wylie (Registered Nurse) until 13.00 and Mrs Geraldine Borelan thereafter	**Date manager registered:** Mrs Geraldine Borelan (Acting – no application required)
Categories of care: Nursing Homes (NH) LD – Learning disability LD(E) – Learning disability – over 65 years	**Number of registered places:** 43

4.0 Inspection summary

An unannounced inspection took place on 2 October 2017 from 11.20 to 15.25.

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 the administration of medicines, the standard of maintenance of medicine records, the management of controlled drugs and the storage of medicines.

No areas for improvement were identified.

Patients stated they were happy in the home.

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	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Geraldine Borelan, Manager, as part of the inspection process and can be found in the main body of the report.

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 required to be taken following the most recent inspection on 27 June 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

During the inspection we met with one patient, two care assistants, one registered nurse, the human resources manager and the manager.

A total of 15 questionnaires were provided for distribution to patients, their representatives, and staff for completion and return to RQIA.

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
- 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 27 June 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 26 October 2016

Areas for improvement from the last medicines management inspection		
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 38 **Stated:** Second time	The registered manger should monitor the records pertaining to thickening agents to ensure the relevant records are maintained.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the management of thickening agents had been reviewed. The sample of records indicated that they were referenced in the patients' personal medication record and care plan. Each administration was recorded and a speech and language assessment report was in place.	
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time	The registered provider should ensure that there are robust arrangements in place for the cold storage of medicines.	**Met**
	Action taken as confirmed during the inspection: The cold storage of medicines had been reviewed. A new medicines refrigerator had been obtained and the daily temperature records indicated the medicines were being stored in accordance with the manufacturer's instructions.	

Area for improvement 3 **Ref:** Standard 4 **Stated:** First time	The registered provider should review the management of pain to ensure this is clearly referenced in a care plan and details how pain would be expressed and assessed.	**Met**
	Action taken as confirmed during the inspection: A sample of patients' care records was examined. Pain management was detailed in a care plan and a pain assessment tool had been completed. The manager advised that a more suitable pain assessment tool was being sought and was expected to be implemented in the near future.	
Area for improvement 4 **Ref:** Standard 29 **Stated:** First time	The registered provider should ensure that the dosage directions on the patient's personal medication record, medication administration record and medicine label correspond.	**Met**
	Action taken as confirmed during the inspection: Improvement in the completion personal medication records was evidenced at the inspection. There was correlation between the personal medication records, administration records and medicine labels for all but a few of the medicines examined. The manager advised that these records would be reviewed with immediate effect. Given these assurances, this area for improvement has been assessed as met.	
Area for improvement 5 **Ref:** Standard 28 **Stated:** First time	The registered provider should develop a system to ensure that the prescribed fluid intake is monitored and achieved.	**Met**
	Action taken as confirmed during the inspection: This system had been developed. A reminder notice was displayed in the dining room. A review of fluid intake records indicated that each administration of fluids was recorded and included the total 24 hour fluid intake.	

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.

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 medicines management training is provided each year and includes the management of diabetes, epilepsy and dementia. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training was completed in June 2017.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. 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 procedures in place to ensure the safe management of medicines during a patient's admission to the home and discharge from the home; and to manage changes to prescribed medicines.

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.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Since the last medicines management inspection, the medicine system had changed and resulted in new storage arrangements for medicines. Medicine trolleys were no longer in use. Each patient's medicines were clearly segregated in locked cupboards and medicines were stored in accordance with the manufacturer's instructions. Internal and external medicines were stored separately. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Staff advised that this new system worked well and was more suitable for medicines administration in this home.

Medicine equipment such as the medicine refrigerator and oxygen equipment were checked at regular intervals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessment, the management of medicines on admission/discharge, controlled drugs and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

With the exception of a few medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. The administrations of those medicines which should be closely monitored were highlighted to staff and the manager. The manager gave an assurance that these would be included in the audit process.

There were robust arrangements in place to alert staff of when medicines prescribed at twice weekly or three monthly intervals were next due for administration.

The management of distressed reactions, swallowing difficulty and pain was reviewed. Of the sample of records examined, the relevant information was recorded in the patient's medicine records and care files. From discussion with staff it was evident that they were knowledgeable regarding patients' individual needs, their swallowing ability, how they would express pain and that any distressed reactions may be due to pain.

When antibiotics were prescribed, a care plan was maintained. This is good practice.

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. They confirmed that most patients were generally compliant with their medicine regimes. In relation to one patient, they described the action taken following the ongoing non-administration of medicines due to swallowing difficulty.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included two staff signatures for the writing and updating of personal medication records and medication administration records; and recording the reason for and outcome of the administration of medicines prescribed on a 'when required' basis e.g. analgesics and anxiolytics.

The management of medicines administered via an enteral feeding tube was reviewed. The patient's feeding regime and care plan were in place. The enteral feed was recorded on the personal medication record and the daily fluid intake was recorded.

Following discussion with the manager and staff, and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to the patients' healthcare needs.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the administration of medicines, the standard of record keeping and care planning. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

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.

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.

We met briefly with two patients, who confirmed that they were happy in the home and could take their medicines. For those patients who could not verbalise their feelings in respect of their care, we noted them to be relaxed and comfortable in their surroundings and in their interactions with staff.

We spoke with staff and comments included:

"I love my job; it's a great place to work."
"We get good support."
"I enjoy my work."
"We are provided with plenty of training."
"This place is very homely for the patients."

Of the questionnaires that were issued, four were returned from patients and one from staff. The responses indicated that they were very satisfied/satisfied with all aspects of the care in relation to the management of medicines.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to listening to and valuing patients and taking account of the views of patients.

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. These were not examined at the inspection. Staff advised that they were familiar with them and were kept up to date of any changes.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents and advised of how incidents were shared with them to inform learning and change of practice, if necessary. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

An effective auditing system was in place. Medicines management was audited each week by the staff and management audits were completed regularly. The community pharmacist also audited medicines management throughout the year. A review of the audit records indicated that largely satisfactory outcomes had been achieved. Staff advised of the procedures which would be followed if a discrepancy or an area for improvement was identified. It was suggested that to enhance the audit process, staff should consider recording the stock balance of medicines carried forward to the next medicine cycle.

Following discussion with the 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. They advised that management were open and approachable and willing to listen. They also stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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