Unannounced Medicines Management Inspection Report
26 October 2016

Queenscourt

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

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Queenscourt took place on 26 October 2016 from 10.25 to 15.25.

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 had been trained and deemed competent. There were systems in place to ensure that the management of medicines was in compliance with legislative requirements and standards. However, one area for improvement was identified in relation to the cold storage of medicines and a recommendation was made.

Is care effective?

There were systems in place to ensure patients were receiving their medicines as prescribed. Care plans regarding medicines management were in place for some conditions e.g. distressed reactions, epilepsy and swallowing difficulty. However, to ensure that the management of medicines supports the delivery of effective care, areas for improvement were identified in relation to pain management and medicines records; four recommendations were made, this included one recommendation which was stated for a second time.

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. 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. The manager advised of the planned improvements regarding medicines management. Written policies and procedures for the management of medicines were in place which supported the delivery of care. There were 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. Please also refer to Section 4.2 and 5.0 of this report.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	5

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Stella Law, Acting Manager, and the registered nurses on duty, 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 24 May 2016.

2.0 Service details

Registered organisation/registered person: Manor Healthcare Ltd/Mr Eoghain King	**Registered manager:** See below
Person in charge of the home at the time of inspection: Ms Stella Law	**Date manager registered:** Ms Stella Law (application not yet submitted)
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 43

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 member of care staff, two registered nurses and the registered manager.

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 24 May 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 8 May 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must closely monitor the administration of medicines prescribed as multiple doses; any further discrepancies must be investigated and reported to RQIA.	**Met**
	Action taken as confirmed during the inspection: There was evidence that medicines prescribed as multiple doses were included in the monthly audit process. The majority of these medicines were now supplied in the monitored dosage medicine system and no discrepancies were noted at the inspection.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must investigate the observations made in risperidone liquid and forward details of the findings and action taken in a written report to RQIA.	**Met**
	Action taken as confirmed during the inspection: A written report of the outcomes of the investigation was received by RQIA on 16 May 2014. No discrepancies were observed in the audit trails completed on this medicine at the inspection.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should ensure that all controlled drugs in Schedule 4 (Part 1) are denatured and therefore rendered irretrievable, by two members of trained staff, before being placed into waste bins.	**Met**
	Action taken as confirmed during the inspection: There was evidence that Schedule 4 (Part 1) controlled drugs had been denatured by two registered nurses prior to disposal.	
Recommendation 2 **Ref**: Standard 37 **Stated:** First time	The registered manager should review the audit process to ensure a variety of medicine formulations are included, as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: A review of the internal audit records indicated that audits were usually performed on medicines supplied as tablets, patches or capsules. There were no routine audits on other formulations of medicines. A new medicine system had been introduced on 24 October 2016. Staff had commenced running stock balances for a number of medicines including inhaled medicines and sachets. Following discussion with the manager and staff it was established that a new auditing system was being implemented as a result of the new medicine system and this would be focusing on all formulations of medicines. Due to these assurances this recommendation was assessed as met.	
Recommendation 3 **Ref**: Standard 38 **Stated:** First time	The registered manager should review the management of medicines for distressed reactions to ensure the relevant records are being maintained.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of patients' records indicated that the relevant records were maintained.	

Recommendation 4 **Ref**: Standard 38 **Stated:** First time	The registered manger should monitor the records pertaining to thickening agents to ensure the relevant records are maintained.	**Partially Met**
	Action taken as confirmed during the inspection: There was evidence that the prescribed consistency of thickened fluids was recorded on the patients' care plan and personal medication record. Whilst there were records of some administration by the registered nurses, administration by care staff was not recorded. This recommendation is stated for a second time.	
Recommendation 5 **Ref**: Standard 32 **Stated:** First time	The registered manager should confirm that the appropriate restrictors have been affixed to the window in the treatment room to maximise the security of the medicines.	**Met**
	Action taken as confirmed during the inspection: There were restrictors affixed to the window in the treatment room.	

4.3 Is care safe?

The manager confirmed that medicines were managed by staff who have been trained and deemed competent to do so, and that an induction process was in place for registered nurses and for care staff who had been delegated medicine related tasks. She confirmed there were arrangements in place to monitor the impact of training and that she had completed competency assessments and supervision for some but not all staff; and that this would be completed at the earliest opportunity. A sample of records was provided at the inspection. Refresher training regarding enteral feeding was provided in the last year. The most recent training was in relation to the new medicines system in September 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 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 the patient was on temporary leave 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. 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.

The storage of medicines was reviewed. Medicines were stored safely and securely and each patient's medicines were clearly segregated. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. One medicine refrigerator was in use. There was evidence that the refrigerator thermometer had been faulty since August 2016. The record of temperatures indicated that minimum and maximum temperatures had not been monitored and the same current temperature had been recorded. Staff advised that a new medicine refrigerator had been ordered. A number of medicines which did not require refrigeration were removed at the inspection. A recommendation was made.

Areas for improvement

The cold storage of medicines should be reviewed to ensure that:

- daily maximum and minimum temperatures are monitored and recorded
- any issues or concerns relating to cold storage are followed up in a timely manner
- medicines are stored at the correct temperature

A recommendation was made.

Number of requirements	0	**Number of recommendations**	1

4.4 Is care effective?

A new medicine system had commenced on 24 October 2016. The sample of medicines examined had been administered in accordance with the prescriber's instructions. There were arrangements in place to alert staff of when doses of weekly or three monthly medicines were due. Some advice was given at the inspection to enhance the current procedures.

A staff communication book was maintained and viewed at each shift change. This included information regarding medicines and the outcomes of visits from/consultations with other healthcare professionals.

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. 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. A care plan was maintained. These medicines were rarely required. Staff advised that any ongoing administration would be reported to the prescriber for review and confirmed that the reason for and outcome of any administration would be recorded in the patient's daily notes.

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 could verbalise pain, and a pain assessment tool was used as needed. However, for patients who could not verbalise pain or had little communication, there was no evidence that a pain assessment tool was in use or records of how staff would know the patient was in pain. Staff provided examples of how patients would communicate pain and it was acknowledged that the staff have worked in the home for several years and were knowledgeable regarding the patients' needs. This information should be clearly recorded. A care plan was maintained for some but not all patients prescribed medicines to control pain. 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. When administered by the registered nurses, this was recorded. However, there was no system in place to enable the care staff to record any administration. A record of all administered medicines must be maintained. A recommendation was stated for a second time.

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 format of some medicine records had changed with the new medicine system. Whilst most of these had been maintained in a satisfactory manner, it was noted that for several patients a personal medication record was not in place. Staff were using the printed medication administration records to direct the administration of medicines. This was discussed with staff who advised that these records were in the process of being prepared. The manager confirmed by telephone on 27 October 2016 that a personal medication record was in place for all patients. It was noted that for a small number of medicines the dosage directions on the personal medication record, corresponding medication administration record and medicine label differed. These should state the same dosage directions per medicine. A recommendation was made.

The management of enteral feeding was examined. Fluid intake charts had been maintained in a largely satisfactory manner, and clearly stated when the feed, flushes and medicines were administered. However, the total volume of fluid intake per 24 hours was not recorded. A system should be in place to ensure that this is checked each day to evidence that the prescribed target volume has been achieved. A recommendation was made.

Following discussion with the manager and staff and a review of the care files, 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:

- a pain assessment tool is used as applicable and is kept in the patient's file
- details of how the patient would communicate pain are recorded
- where pain relief medicines are prescribed, this is referenced in a care plan

A recommendation was made.

The necessary arrangements should be made to ensure that the dosage directions on the patient's personal medication record, medication administration record and medicine label correspond. A recommendation was made.

The management of thickening agents should be reviewed to ensure that records of administration are fully maintained. A recommendation was stated for a second time.

Where patients are prescribed a daily fluid intake, the patient's fluid intake should be monitored and recorded on a daily basis to ensure that the target intake is achieved. A recommendation was made.

Number of requirements	0	Number of recommendations	4

4.5 Is care compassionate?

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.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients were treated courteously, with dignity and respect. Good relationships were evident.

It was not possible to ascertain the views and opinions of patients.

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?

The manager advised of the planned areas for improvement in the home and of the actions that were currently ongoing.

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 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 and advised of how any learning would be shared with staff and implemented.

The auditing process for medicines management was reviewed. Management and staff had completed weekly and monthly audits. A review of the internal audit records indicated that largely satisfactory outcomes had been achieved. As mentioned previously these should focus on a variety of medicines and the manager advised of the new system which had commenced and the planned changes to the auditing system. These included daily running stock balances for medicines, dates of opening on medicines and a record of the stock carried forward to the next medicine cycle. It was acknowledged that some of these actions had

commenced. She also advised that following the inspection an action plan had been developed and was being implemented.

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

Not all of the recommendations made at the last medicines management inspection had been addressed effectively. 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 staff individually, at shift handover and at team 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 Ms Stella Law, Acting Manager and the registered nurses on duty, 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 via web portal 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	
Recommendations	
Recommendation 1 **Ref**: Standard 38 **Stated:** Second time **To be completed by:** 25 November 2016	The registered manger should monitor the records pertaining to thickening agents to ensure the relevant records are maintained.
	Response by registered provider detailing the actions taken: Training has commenced insuring all staff will receive and update their skills regarding how to manage thickening agents. The Home manager has developed a comprehensive monitoring system that will ensure that the aforementioned records are monitored and maintained
Recommendation 2 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 25 November 2016	The registered provider should ensure that there are robust arrangements in place for the cold storage of medicines.
	Response by registered provider detailing the actions taken: We have introduced a new system to ensure that the daily maximum and minimum temperature of the medicine fridge is measured/monitored appropriately. All medicines are stored at the correct temperatures. We have also purchased a new fridge temperature monitor.
Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 25 November 2016	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.
	Response by registered provider detailing the actions taken: Our resident pain management system has been reviewed and amended. We now have more appropriate tools and protocols for assessing a resident in pain.

Recommendation 4 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 25 November 2016	The registered provider should ensure that the dosage directions on the patient's personal medication record, medication administration record and medicine label correspond.
	Response by registered provider detailing the actions taken: We have introduced and implemented a new scheme that ensures all medication records are accurate
Recommendation 5 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 25 November 2016	The registered provider should develop a system to ensure that the prescribed fluid intake is monitored and achieved.
	Response by registered provider detailing the actions taken: A system is now in place to make sure that prescribed fluid intake is appropriately monitored and recorded.

Please ensure this document is completed in full and returned via web portal

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