Unannounced Medicines Management Inspection Report
30 August 2016

Marina Care Home

Type of Service: Nursing Home
Address: Shore Road, Ballyronan, BT45 6JA
Tel No: 028 7941 8770
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Marina Care Home took place on 30 August 2016 from 09.25 to 14.10.

This was the first medicines management inspection to the home since it was re-registered in April 2016, following a change of ownership and registration of a new registered provider. A new manager was appointed in June 2016.

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 most areas of the management of medicines supported the delivery of safe care and positive outcomes for patients. There were arrangements for staff training and assessment of competency. Medicines were stored safely and securely. Two areas for improvement were identified; one in relation to the standard of maintenance of personal medication records and the other in relation to the storage of medicines. One requirement and one recommendation were made.

Is care effective?

The management of medicines supported the delivery of effective care. There were largely satisfactory systems in place to ensure patients were receiving their medicines as prescribed. Some areas for improvement were identified in relation to record keeping and care plans. Three recommendations were made, one of 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. The patient spoken to was complimentary about their care in the home and the management of their medicines. No requirements or recommendations have been made.

Is the service well led?

Some areas of the service were 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. Staff were aware of their roles and responsibilities. Systems were in place to enable management to identify and cascade learning from any medicine related incidents. However, one area in relation to the development of a robust auditing process was identified for improvement and a requirement was 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.

For the purposes of this report, the term 'patients' will be used to described those living in Marina Care Home which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Una Mc Taggart, Applicant Manager and Mrs Briege Kelly, Registered Provider (by telephone after the inspection), 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 11 May 2016.

2.0 Service details

Registered organisation/registered person: Burnview Healthcare Ltd/ Mrs Briege Agnes Kelly	**Registered manager:** See below
Person in charge of the home at the time of inspection: Mrs Una McTaggart (Applicant Manager)	**Date manager registered:** Ms Una McTaggart (application received - registration pending)
Categories of care: NH-I, NH-DE, RC-I, RC-MP(E)	**Number of registered places:** 33

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

During the inspection the inspector met with one patient, one member of senior care staff, one registered nurse and the applicant 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 11 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 the next care inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 11 April 2014

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should ensure that two nurses/suitably trained staff are involved in the disposal of each medicine and both persons should sign the disposal record.	**Met**
	Action taken as confirmed during the inspection: Examination of the records of the disposal of medicines indicated that this practice occurs.	
Recommendation 2 **Ref**: Standard 38 **Stated:** First time	The registered manager should closely monitor the personal medication records to ensure that these are up to date at all times.	**Not Met**
	Action taken as confirmed during the inspection: There was no evidence that personal medication records were monitored on an ongoing basis to ensure these were accurate. Examination of a sample of these records showed that significant improvement was necessary. This recommendation has not been met and due to the findings a requirement regarding the management of personal medication records was made.	
Recommendation 3 **Ref**: Standard 37 **Stated:** First time	The registered manager should review the management of distressed reactions to ensure the relevant records are maintained.	**Partially Met**
	Action taken as confirmed during the inspection: There was evidence that care plans had been implemented for some, but not all, patients. The reason for and outcome of the administration of "when required" medicines had not been recorded on all occasions. This recommendation was assessed as partially met and is stated for a second time.	

4.3 Is care safe?

The manager advised that an induction process was in place for registered nurses, agency nurses and for care staff who had been delegated medicine related tasks. She confirmed that medicines were managed by staff who have been trained and deemed competent to do so. The impact of training was monitored through regular team meetings, monthly supervision and was also reviewed through annual appraisal. The manager confirmed that the appraisal process had commenced and had been completed for some staff. Refresher training in general medicines management was provided in May 2016 and records were provided at the inspection. Recent supervision sessions had included the management of thickened fluids and the completion of fluid charts.

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. However, one medicine was noted to be out of stock for three days; the manager confirmed that stock was due after the inspection and provided assurances that staff would be reminded to review stock levels.

Some of the medicine records were well maintained and facilitated the audit process. However, significant improvement is required in the completion of personal medication records. A number of these were not up to date and/or were incomplete. Several did not match the corresponding medication administration record and there were some duplicated and amended entries. For a small number of these records it was difficult to establish which medicines were currently prescribed or had been discontinued. It was emphasized that these records may be used by other healthcare professionals and the information must be accurate at all times to facilitate the delivery of safe care. A requirement was made. The manager confirmed that two of these records would be rewritten immediately after the inspection.

Two trained staff were not routinely involved in the transcribing of medicines information on the medication administration records. It was acknowledged that this was the expected practice and the manager advised that this would be addressed with all relevant staff. It was agreed that this would be closely monitored.

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. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged.

Appropriate arrangements were in place for administering medicines in disguised form.

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. Medicine storage areas were clean, tidy and well organised. The date of opening

was recorded on medicines with a limited shelf life, e.g. insulin, eye preparations; however, three eye preparations had passed the expiry date and were removed from the medicine trolley. A recommendation regarding the management of limited shelf life medicines was made. The dosage directions on one insulin pen were queried with regard to the dose stated and the dose on the personal medication record. This was clarified by the manager and it was suggested that the labelling of insulin should be reviewed in consultation with the prescriber and community pharmacist.

Medicine refrigerators and oxygen equipment were checked at regular intervals. Staff were reminded that the oxygen mask must be covered when not in use. It was agreed that this would be addressed after the inspection.

Areas for improvement

A robust system must be developed to ensure that personal medication records are fully and accurately maintained at all times. A requirement was made.

The management of limited shelf life medicines should be reviewed to ensure that stock is replaced when the expiry date is reached. A recommendation was made.

Number of requirements	1	Number of recommendations	1

4.4 Is care effective?

The majority of the sample of medicines which were examined had been administered in accordance with the prescriber's instructions. A small number of discrepancies were observed and highlighted at the inspection. There was evidence that time critical medicines had been administered at the correct time.

The management of injectable medicines should be reviewed. It was difficult to ascertain the date of the next administration for one injection and it could not be confirmed if the injection had been administered in April 2016. The manager advised that she would look into this matter. The audit trail on two anticoagulant injections could not be concluded. It was recommended that a system should be developed to ensure that robust arrangements are in place for injectable medicines.

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. The reason for and the outcome of administration were not routinely recorded. A care plan was maintained for some but not all patients prescribed these medicines. The recommendation made at the last medicines management inspection was stated for a second time.

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 any pain, and a pain tool was used as needed. Staff also advised that a pain assessment was completed as part of the admission process. A care plan was not always maintained and 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. Each administration was recorded and care plans and speech and language assessment reports were in place.

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.

Following discussion with the manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medicines management.

Areas for improvement

A system should be developed to ensure that there are robust arrangements in place for the management of injectable medicines. A recommendation was made.

The management of distressed reactions should be reviewed to ensure that this is recorded in a care plan and the reason and outcome of each administration is recorded. A recommendation was stated for a second time.

Where medicines are prescribed to manage pain, this should be referenced in the patient's care plan. A recommendation was made.

Number of requirements	0	Number of recommendations	3

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.

The patient spoken to at the inspection stated that they were content with their care in the home and had no concerns regarding the management of their medicines. They advised that staff responded in a timely manner to any requests for medicines e.g. pain relief. They spoke positively about the staff.

It was acknowledged that a separate record was in place to detail if the patient had any preferences with regard to the administration of medicines e.g. location – day room, dining room, bedroom and type of drink e.g. water, juice, to be given with medicines.

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?

Following the change in ownership, the registered provider, had implemented new written policies and procedures for the management of medicines. There was evidence that the staff had commenced reviewing these and had signed that they understood the policies.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents.

The registered provider and manager advised of the areas which had been identified for improvement and this included records management, training, care plans and recruitment. However, a robust auditing system for medicines management was not in place. Although there were auditing arrangements in place for medicine equipment, warfarin and controlled drugs, and a recent audit had been completed by the community pharmacist, audits which cover all aspects of medicines management were yet to be fully embedded in the home. A small number of audit trails could not be concluded as the date of opening and/or the quantity of medicine carried forward to the new medicine cycle was not recorded. This is best practice and should be implemented. There were some discrepancies in the audit trails and areas for improvement were identified within the standard of record keeping and storage of medicines; a system which covers all aspects of medicines management must be developed and implemented. A requirement was made.

Following discussion with the manager and 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 through handover, individually with staff and at team meetings.

Areas for improvement

A robust auditing system which covers all aspects of medicines management must be developed and implemented. A requirement was made.

Number of requirements	1	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 Una Mc Taggart, Applicant Manager and Mrs Briege Kelly, Registered Provider (by telephone after the inspection), 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 the 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 taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to pharmacists@rqia.org.uk 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

Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 30 September 2016	The registered provider must make the necessary arrangements to ensure the personal medication records are fully and accurately maintained.
	Response by registered provider detailing the actions taken: New home operators have provided new medication record sheets which are fully and accurately maintained.
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 30 September 2016	The registered provider must develop and implement a robust auditing system which covers all aspects of medicines management.
	Response by registered provider detailing the actions taken: New home operators have implemented a new auditing system which has commenced September 2016.
Recommendations	
Recommendation 1 **Ref**: Standard 37 **Stated:** Second time **To be completed by:** 30 September 2016	The registered manager should review the management of distressed reactions to ensure the relevant records are maintained.
	Response by registered provider detailing the actions taken: All residents that have distressed reacton have a careplan in place with all relevant information. Residents are monitored after medication is administred and all outcomes documentated..Distressed reaction training .is planned for 6th October 2016 for all staff.
Recommendation 2 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 30 September 2016	The registered manager should review the management of limited shelf life medicines to ensure that stock is replaced when the expiry date is reached.
	Response by registered provider detailing the actions taken: All nurses have been supervised in all aspects of expiry dates and are now more aware of the importance of being proactive.
Recommendation 3 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure there are robust arrangements in place for the management of injectable medicines.
	Response by registered provider detailing the actions taken: The new home operators have implemented a injectable reminder sheet which is kept in reidents kardex and the next due date is entered in the nurses diary for follow up.

Recommendation 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should ensure that where medicines are prescribed to manage pain, this is referenced in the patient's care plan.
	Response by registered provider detailing the actions taken: Each resident that is prescribed analgesia has a personal centred, pain care plan which is reviewed monthly or more often if necessary.

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

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