Unannounced Medicines Management Inspection Report
11 April 2017

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 11 April 2017 from 10.00 to 14.30.

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. No requirements or recommendations were made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Cares plans relating to medicines management were in place. No requirements or 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. Patients consulted with confirmed that they were administered their medicines appropriately. 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. 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.

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	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Una McTaggart, Registered 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.

1.2 Actions/enforcement taken following the most recent care inspection

The most recent care inspection was completed on 3 November 2016.

Following intelligence received by RQIA on 24 January 2017 regarding the quality of care, the registered person was requested to investigate these issues; a satisfactory response was received on 9 February 2017.

2.0 Service details

Registered organisation/registered person: Burnview Healthcare Ltd Mrs Briege Agnes Kelly	**Registered manager:** Mrs Una McTaggart
Person in charge of the home at the time of inspection: Mrs Una McTaggart	**Date manager registered:** 11 November 2016
Categories of care: NH-I, 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 incidents register – it was ascertained that no medicine related incidents had been reported to RQIA since the last medicines management inspection

We met with three patients, two registered nurses, a senior manager from Burnview Healthcare Ltd 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.

Fifteen questionnaires regarding medicines management were issued to patients, their relatives/representatives and staff, with a request that these were returned within one week of 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 3 November 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 30 August 2016

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time	The registered provider must make the necessary arrangements to ensure the personal medication records are fully and accurately maintained.	**Met**
	Action taken as confirmed during the inspection: The personal medication records which were examined at the inspection had been well maintained.	
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered provider must develop and implement a robust auditing system which covers all aspects of medicines management.	**Met**
	Action taken as confirmed during the inspection: The auditing system had been further developed and included a variety of medicines, records and equipment. There was evidence of the corrective action taken following the identification of areas for improvement.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 37 **Stated:** Second time	The registered manager should review the management of distressed reactions to ensure the relevant records are maintained.	**Met**
	Action taken as confirmed during the inspection: A detailed care plan was in place and records of administration were maintained. The reason and outcome of administration was recorded on most occasions. Following discussion, the registered manager advised that she planned to implement a separate administration record for medicines prescribed on a 'when required' basis.	
Recommendation 2 **Ref:** Standard 30 **Stated:** First time	The registered manager should review the management of limited shelf life medicines to ensure that stock is replaced when the expiry date is reached.	**Met**
	Action taken as confirmed during the inspection: The samples of limited shelf life medicines examined had been marked with the date of opening and were within the expiry date. Staff advised that these medicines were checked regularly.	
Recommendation 3 **Ref:** Standard 28 **Stated:** First time	The registered provider should ensure there are robust arrangements in place for the management of injectable medicines.	**Met**
	Action taken as confirmed during the inspection: A new system had been developed; a separate administration record detailing the date of administration and date when the next dose was due was recorded. In addition the date was recorded in the diary. This system was well embedded into routine practice.	
Recommendation 4 **Ref:** Standard 4 **Stated:** First time	The registered provider should ensure that where medicines are prescribed to manage pain, this is referenced in the patient's care plan.	**Met**
	Action taken as confirmed during the inspection: There was evidence of pain management care plans and pain assessment tools for patients	

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. Refresher training in medicines management and diabetes was provided earlier this year. Training in the management of dysphagia was planned for later this month.

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. The management of prescription forms was discussed. It was agreed that any forms held in the home for uplift by the community pharmacist would be locked away to maximise safe custody.

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 discharge from the home. Written confirmation of medicine regimes was obtained.

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 e.g. warfarin. 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. 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?

With the exception of a few liquid medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. It was agreed that the registered manager would increase the frequency of audits on liquid medicines, as part of the internal audit process.

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 weekly or three monthly medicines were due.

The management of four antibiotics was examined. The advice of the healthcare professional had been recorded in the patients' notes and the antibiotics had been obtained in a timely manner. With the exception of a delay in the administration of the first dose of two patient's antibiotics, the other doses had been administered as prescribed. This was discussed in detail and the registered manager advised of the corrective action to ensure prompt administration of antibiotics from the day of the inspection onwards.

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 and constipation. This was detailed in a care plan. The reason for and the outcome of administration was usually recorded. To ensure that this is recorded on all occasions, a new recording system is planned to be implemented (see also Section 4.2).

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 assessment tool was used as needed and also as part of the admission process. A care plan was maintained.

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.

Medicine records were well maintained and facilitated the audit process. The standard of record keeping was acknowledged. Staff were reminded that obsolete records must be discontinued and removed from the kardex folder.

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. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to the healthcare needs of the patients.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

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.

Staff provided details of some patients' preferences regarding the administration of their medicines and those who like to have their morning medicines at a later time, due to sleeping longer in the morning. Staff were aware of the time intervals between medicines.

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

The patients spoken to at the inspection advised that they were content with the management of their medicines. They were complimentary about the staff. However, two patients raised specific concerns relating to their care; details were provided to the registered manager at feedback. She agreed to look into these issues. Details were also shared with the care inspector for the home.

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.

As part of the inspection, questionnaires were issued to patients, their relatives/representatives and staff. There were no questionnaires received by RQIA at the time of issuing this report.

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 staff.

In relation to the regional safeguarding procedures, staff confirmed they were familiar with these and were aware of when incidents must be considered as reportable to the adult safeguarding lead. There was evidence that training had been provided. A policy was in place and detailed the names of the lead and the pathway to follow to report incidents.

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 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. These were discussed with staff at supervision.

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

The requirements and recommendations made at the last medicines management inspection had been addressed.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with to them.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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