Unannounced Medicines Management Inspection Report
25 January 2017

The Model Care Home

Type of Service: Nursing Home
Address: 1 Portrush Road, Ballymoney, BT53 6BX
Tel no: 028 2766 4502
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of The Model Care Home took place on 25 January 2017 from 10.35 to 14.45.

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. Specific areas of medicines management were detailed in the patients' care records examined. 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 The Model 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 Mr Vasco Alves, Manager, Mrs Carol Craig, Support Manager and a registered nurse on duty, as part of the inspection process. Details 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

There were no further actions required to be taken following the most recent inspection on 22 November 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons (No. 11) Limited/ Dr Maureen Claire Royston	**Registered manager:** See below
Person in charge of the home at the time of inspection: Mr Vasco Alves	**Date manager registered:** Mr Vasco Alves (registration pending)
Categories of care: NH-LD(E), NH-I, RC-I, RC-PH	**Number of registered places:** 36

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 patient, one member of care staff, one registered nurse, the activities co-ordinator, the support manager and the acting 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.

Twenty five questionnaires were issued to staff, patients and relatives/patient representatives, that these be completed and returned within one week of the inspection.

A sample of the following records was examined at 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 22 November 2016

There were no requirements or recommendations made at the unannounced care inspection to the home on 22 November 2016.

4.2 Review of requirements and recommendations from the last medicines management inspection 23 November 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should ensure that when a medicine is administered ‘‘when required’’ for the management of distressed reactions, the reason for the administration and the outcome are recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: Satisfactory arrangements were in place to record the reason for and on outcome of any medicines administered for the management of distressed reactions.	
Recommendation 1 **Ref**: Standard 38 **Stated:** Second time	The registered manager should ensure that when care assistants administer topical medicines, there are arrangements in place to oversee the completion of records and evidence of this review.	**Met**
	Action taken as confirmed during the inspection: The management of external preparations has been recently reviewed and new procedures were currently being implemented. There was evidence that this area of medicines management was included in the internal audit process.	

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 and following incidents. Refresher training in medicines management was provided in December 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 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.

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?

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There was evidence that time critical medicines had been administered at the correct time.

There were robust arrangements in place to alert staff of when doses of mid-weekly, weekly, monthly or three monthly medicines were due. The medicine administration records had been marked out to indicate the day of administration. This is best practice.

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 recorded. A care plan was maintained.

The management of pain was examined. Staff advised that a pain assessment was completed for all patients in the home and was assessed on a monthly basis. Pain management was detailed in the care plans examined. The sample of records examined indicated that pain controlling medicines had been administered as prescribed. Staff were aware of the need to ensure that the pain was well controlled and the patient was comfortable. They advised that most patients could tell the staff if they were in pain. A record of the reason for and the outcome of the administration were recorded.

The management of swallowing difficulty was examined. Staff were knowledgeable regarding each patient's prescribed consistency of thickened fluids. Details were recorded on the patients' personal medication record. Records of administration, care plans and speech and language assessment reports were in place. Staff were reminded that the fluid consistency should also be recorded on the fluid intake charts.

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. Areas of good practice were acknowledged. They included additional administration records for transdermal patches, high risk medicines and laxatives. Specific records were also in place to record the reason for and outcome of any medicine prescribed on a "when required" basis.

Largely satisfactory arrangements were in place for the management of medicines administered via the enteral feeding route. Some incomplete entries on the fluid intake charts were noted. The manager confirmed by email on 26 January 2017 that he had commenced supervision sessions with staff to address this issue.

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

Throughout the inspection, it was evident that there were good relationships between the staff and the patients. The staff were kind, friendly and courteous to the patients.

The patient spoken to advised that she had no concerns regarding the management of their medicines and was complimentary regarding their care in the home. They advised that staff would respond in a timely manner to any requests they had.

Comments included:

"The staff are very good."
"They look after you."

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 process questionnaires in relation to medicines management were issued to patients, relatives/patients' representatives and staff. No questionnaires had been returned 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. These had been reviewed in March 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 number of medicine related incidents had been reported since the last medicines management inspection and were discussed. There was evidence of the action taken and learning which had been implemented. As part of these improvements, extra support was being provided to the home internally and externally to drive the improvement and put systems in place to ensure that it was sustained.

A variety of internal auditing systems were in place for medicines management. They included daily, weekly and monthly audits. An overarching audit was completed by management monthly or quarterly; and in addition audits were completed by the community pharmacist. A review of the internal audit records indicated that largely satisfactory outcomes had been achieved. Where areas for improvement had been identified, an action plan was developed and shared with staff to read, address and sign; these areas were also reiterated at staff meetings.

Following discussion with management, registered nurses and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with management.

The staff spoken to at the inspection were very positive about their work and were very complimentary about the relationships between staff and the ongoing support provided by the staff team and the manager.

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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