Unannounced Medicines Management Inspection Report
9 January 2017

Aughnacloy House

Type of Service: Nursing Home
Address: 2 Tandragee Road, Lurgan, Craigavon, BT66 8TL
Tel no: 028 3834 6400
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Aughnacloy House took place on 9 January 2017 from 10.50 to 15.40.

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. However one area of improvement was identified in relation to the management of medication changes. A requirement was 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. One area of improvement was identified in relation to the records in place for the management of distressed reactions. A recommendation was made for the 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. There were no areas of improvement identified

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. There were no areas of improvement identified.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Constance Mitchell, Registered Manager, 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 medicines inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 4 February 2016.

2.0 Service details

Registered organisation/registered person: MD Healthcare Ltd Mrs Lesley Catherine Megarity	**Registered manager:** Ms Constance Mitchell
Person in charge of the home at the time of inspection: Ms Constance Mitchell	**Date manager registered:** 12 February 2015
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E)	**Number of registered places:** 71

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 care assistant, two registered nurses and the registered manager.

A number of questionnaires were issued to patients, relatives/representatives and staff, with a request that they were returned within one week from the date 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
- medicine audits
- care plans
- medicines storage temperatures
- controlled drug record book

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 4 February 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 4 February 2016

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 18 **Stated:** First time	The registered manager should review and revise the management of medicines which are prescribed to be administered "when required" for distressed reactions as detailed in the report.	**Partially Met**
	Action taken as confirmed during the inspection: Care plans for the management of distressed reactions were now in place. However, the reason for and outcome of each administration were not routinely being recorded. The recommendation has been stated for a second time.	

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 assistants who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. The registered manager advised that annual competency assessments were currently being completed with all registered nurses and care assistants who have been delegated medication related tasks. Refresher training on the management of medicines is planned.

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 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. However the audits which were completed on one patient's medication indicated that one recent change had not been managed appropriately resulting in the incorrect dose being administered on a number of occasions, due to two supplies being in use. The registered manager was requested to investigate this discrepancy, inform the appropriate persons including the prescriber and family. An incident report form including the action taken to prevent a recurrence was received by RQIA on 10 January 2017. The registered provider must ensure that only one supply of each medicine is available for administration. A requirement was made.

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. Registered nurses were reminded that the abbreviation "iu" should not be used and that dates of opening should be recorded on insulin pens. It was acknowledged that the pens would be finished before their expiry date was reached.

Appropriate arrangements were in place for administering medicines and nutrition via the enteral route.

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. With the exception of insulin pens, 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

The registered provider must ensure that only one supply of each medicine is available for administration for each patient. A requirement was made.

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

4.4 Is care effective?

The majority of medicines which were audited had been administered in accordance with the prescriber's instructions. Discrepancies in the administration of two medicines (furosemide and Clexane) were highlighted for close monitoring. 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 and monthly medicines were due.

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. Care plans were maintained. 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 had not been recorded on all occasions. A recommendation was made for the second time.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff advised that a pain assessment tool was used with patients who could not verbalise their pain. Staff also advised that a pain assessment is completed as part of the admission process.

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. Care plans and speech and language assessment reports were in place. Administration records were maintained.

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 separate administration records for transdermal patches.

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, nutritional supplements and inhaled 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 medication related issues.

Areas for improvement

The registered manager should review and revise the management of medicines which are prescribed to be administered "when required" for distressed reactions as detailed in the report. A recommendation was made for the second time.

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

4.5 Is care compassionate?

The registered nurses confirmed that patients were offered the opportunity to self-administer their medicines as part of the admission procedure. Patients were not currently responsible for the self-administration of medicines.

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.

As part of the inspection process 20 questionnaires were issued to patients, relatives/ representatives and staff, with a request that they were returned within one week from the date of the inspection. Four patients, one relative and nine members of staff completed and returned the questionnaires. The responses from the patients and eight of the staff were positive and these were recorded as “satisfied” or “very satisfied” with regard to the management of medicines in the home. One relative and one staff member recorded that “there were not enough staff to give the right care” or “to spend time with my mum”. The registered manager was made aware of these comments and agreed to review the staffing levels. The care inspector was also made aware of the comments and it will be followed up at the next care inspection which is planned before 31 March 2017.

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. Management advised that these were currently being reviewed. 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. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents.

A review of the home’s 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.

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

The recommendation made at the last medicines management inspection had been partially met. To ensure that requirements/recommendations 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 either individually or at staff meetings/handovers.

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 Constance Mitchell, Registered Manager, 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 to 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

Statutory requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 9 February 2017	The registered provider must ensure that only one supply of each medicine (for each patient) is available for administration.
	Response by registered provider detailing the actions taken: All staff instructed to be vigilant when receiving medications, especially for short course, additional doses of same medication, to ensure it is highlighted on the PMR and MAR sheets indicating short course and on completion remove additional supply from trolley to reduce the risk of over administration. Staff receiving new monthly cycle to be vigilant when checking medications in to ensure no additional medication boxes or blister packs are put in medication trolley.
Recommendations	
Recommendation 1 **Ref:** Standard 18 **Stated:** Second time **To be completed by:** 9 February 2017	The registered manager should review and revise the management of medicines which are prescribed to be administered “when required” for distressed reactions as detailed in the report.
	Response by registered provider detailing the actions taken: All nurses have been informed that "when required" medication, for distressed reactions are administered the reason for and outcome of each administration must be recorded in daily records. This information has been communicated verbally with nursing staff and a memo has been displayed as an aide memoire.

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

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