Unannounced Medicines Management Inspection Report
1 August 2018

Aughnacloy House

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

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 71 beds that provides care for patients living with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: MD Healthcare Ltd **Responsible Individual:** Mrs Lesley Catherine Megarity	**Registered Manager:** Ms Constance Mitchell
Person in charge at the time of inspection: Ms Constance Mitchell	**Date manager registered:** 12 February 2015
Categories of care: Nursing Homes (NH): I – old age not falling within any other category DE – dementia PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years	**Number of registered places:** 71 A maximum of 33 patients in category NH-DE to be located on the first floor only. The home is approved to provide care on a daily basis for four patients.

4.0 Inspection summary

An unannounced inspection took place on 1 August 2018 from 10.15 to 16.30.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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.

The inspection assessed progress with any areas for improvement identified during and since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the administration of the majority of medicines, the majority of medicine records and the management of controlled drugs.

Two areas for improvement were identified in relation to maintenance of fluid intake charts and management of distressed reactions.

We spoke with two patients who were complimentary regarding the care and staff in the home.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Details of the Quality Improvement Plan (QIP) 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 18 April 2018. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the home was reviewed. This included the following:

- recent inspection reports
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection we met with two patients, one care assistant, four registered nurses, the charge nurse and the registered manager.

We provided the registered manager with 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. We left 'Have we missed you' cards in the home. These inform patients and their representatives how to contact RQIA to tell us of their experience of the quality of care provided. Flyers providing details of how to raise concerns were also left in the home.

We asked the registered manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

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
- care plans
- training records
- medicines storage temperatures

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 18 April 2018

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.

6.2 Review of areas for improvement from the last medicines management inspection dated 24 August 2017

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall investigate the discrepancies highlighted in the management of medicines for one recently admitted patient. The outcome of the investigation including the action taken to prevent a recurrence should be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: The investigation was completed. An incident report form detailing the action taken to prevent a recurrence was forwarded to RQIA.	

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		Validation of compliance
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure that the management of insulin is reviewed and revised to ensure that dates of opening are recorded and doses are not abbreviated.	**Met**
	Action taken as confirmed during the inspection: A review of the management of insulin indicated that records of prescribing and administration had been clearly documented. Abbreviations were not used. The date of opening had not been recorded on all insulin pens. It was acknowledged that this was an oversight and that at the prescribed dose the insulin would have been used within its expiry date. This finding was discussed with the registered manager and registered nurses who provided assurances that the date of opening would be recorded on all insulin pens from the date of the inspection onwards. Due to the assurances provided this area for improvement has been assessed as met.	
Area for improvement 2 **Ref**: Standard 31 **Stated:** First time	The registered person shall ensure that the key to the controlled cupboard is held separately from all other keys by one registered nurse during each shift.	**Met**
	Action taken as confirmed during the inspection: Controlled drug cabinets are available on both floors. The key to each cabinet was held separately from all other keys by one registered nurse on each floor during each shift.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Medicines were managed by staff who have been trained and deemed competent to do so. Training had been provided in August 2017. Update training was planned for September 2018. Records were available for inspection. Competency assessments were in place and were being updated. Care staff had received training on the management of thickening agents and emollient preparations in June 2018. Further training on the management of thickening agents was planned for next week to ensure completion by all relevant staff.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. The deputy manager had provided training for all staff.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and to manage medication changes. Written confirmation of medication regimens were received for new admissions. Personal medication records and hand-written entries on the medication administration records were verified and signed by two registered nurses. This safe practice was acknowledged.

There were systems in place to ensure that medicines were available for administration on all occasions. There was evidence that potential out of stocks were being followed up. Antibiotics and newly prescribed medicines had been received into the home without delay.

Robust arrangements were observed for the management of warfarin. Dosage directions were received in writing. Two staff were involved in any subsequent transcriptions. Separate administration charts were in use and daily stock balances were maintained.

The management of medicines to be administered via the enteral route was examined. A record of the daily regimen including the required water flushes was observed. However, daily fluid intake charts were not maintained. This is necessary to ensure that the recommended daily fluid intake is being achieved. An area for improvement was identified.

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. It had been noted during a recent audit that a number of administrations had not been witnessed by a second member of staff. This was being addressed with all registered nurses. Due to the assurances provided an area for improvement was not specified at this time.

Satisfactory arrangements were in place for the safe disposal of discontinued or expired medicines.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were well organised. A significant amount of chipped paintwork was observed in the treatment rooms. The registered manager advised that the treatment rooms were due to be painted and that a schedule of work was in place. Dates of opening had been recorded on the majority of medicine containers. Medicine refrigerators and oxygen equipment were checked at regular intervals. Satisfactory recordings were observed for the daily room and refrigerator temperatures.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment and the management of medicines on admission.

Areas for improvement

Records of daily fluid intake should be accurately maintained when medicines and nutrition are administered via the enteral route.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The majority of medicines examined had been administered in accordance with the prescriber's instructions. However, some discrepancies were noted and discussed in detail with the registered manager and registered nurses for ongoing 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, monthly or three monthly medicines were due.

The management of medicines to be administered "when required" for distressed reactions was examined for four patients. Dosage directions were recorded on the personal medication records and records of administration had been maintained. However, care plans were not in place for two patients and the reason for and outcome of administration was not being recorded on all occasions. An area for improvement was identified.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Detailed 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. Pain assessment tools were used with patients who could not verbalise their pain.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, care plans and speech and language assessment reports were in place. Records of prescribing and administration, which included the recommended consistency levels, were appropriately maintained.

Registered nurses advised 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 majority of medicine records were well maintained; however, a number of missed signatures for administration were observed. A number of these had been highlighted during the internal audits. It was agreed that this would be discussed with all registered nurses at the nurses meeting which was planned for next week and that it would continue to be closely monitored.

Practices for the management of medicines were audited throughout the month by 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. However, it was noted that action was not always taken if a running stock balance was observed to be incorrect; this was discussed under governance arrangements in Section 6.7.

Following discussion with the registered manager, charge nurse and registered nurses, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in patient care.

Areas of good practice

There were examples of good practice in relation to the standard of most records, care planning and the administration of medicines.

Areas for improvement

The management of distressed reactions should be reviewed and revised. Detailed care plans should be in place. The reason for and outcome of each administration should be recorded.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We observed the administration of medicines to a small number of patients at lunchtime. The registered nurses engaged the patients in conversation and explained that they were having their medicines.

Throughout the inspection, it was found that there were good relationships between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity. It was clear from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes. Patients were observed to be relaxed and comfortable.

We spoke with two patients who were complimentary regarding the care provided and staff in the home. Comments included:

"I love it here."
"It took me a while to settle in but I am happy now."
"The staff are great."
"I am in no pain. I sleep like a log."
As part of the inspection process, we issued 10 questionnaires to patients and their representatives, none were returned within the specified time frame.

Any comments from patients and their representatives in questionnaires received after the return date (two weeks) will be shared with the registered manager for information and action as required.

Areas of good practice

Staff were observed to listen to patients and to take account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

We discussed arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. Arrangements were in place to implement the collection of equality data within Aughnacloy House.

Written policies and procedures for the management of medicines were in place. They were not reviewed at the inspection.

Medicine related incidents reported since the last medicines management inspection were discussed and there was evidence of the action taken and learning implemented following these incidents. Registered nurses advised that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff advised that they were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were examined. Management advised of the auditing processes completed by both staff and management. Areas identified for improvement were detailed in an action plan which was shared with staff to address and there were systems in place to monitor improvement. As stated in Section 6.5, registered nurses did not always inform management if a discrepancy in the running stock balance had been observed. This was discussed with registered nurses and the registered manager. The

registered manager advised that the findings of this inspection would be discussed in detail with all registered nurses at the planned nurses meeting and that they would be made aware of the need to escalate any issues identified.

The staff we met with spoke positively about their work and advised there were good working relationships in the home with staff and the registered manager. They stated they felt well supported in their work.

We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date.

Staff advised that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with all staff without delay.

No online questionnaires were completed by staff with the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement 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 if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 1 September 2018	The registered person shall ensure that records of daily fluid intake are accurately maintained when medicines and nutrition are administered via the enteral route. Ref: 6.4
	Response by registered person detailing the actions taken: The Registered Manager implemented appropriate documentation on 01.08.2018, the day of the inspection, to ensure that all fluid intake administered via an enteral tube is accurately recorded and maintained. This will be closely monitored.
Area for improvement 2 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 1 September 2018	The registered person shall closely monitor the management of distressed reactions. Detailed care plans should be in place. The reason for and outcome of each administration should be recorded. Ref: 6.5
	Response by registered person detailing the actions taken: The Registered Manager discussed the importance of detailed care plans with reason and outcome for management of distressed reactions with nurses following the inspection and again at a nurse meeting held on 22.08.2018. The Registered Manager will continue to monitor this area of care through the auditing process.

Please ensure this document is completed in full and returned via the Web Portal

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