Unannounced Medicines Management Inspection Report
21 September 2017

Greenpark

Type of Service: Nursing Home
Address: 15 Keady Road, Armagh, BT60 4DH
Tel No: 028 3752 7445
Inspector: Paul Nixon

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 62 beds that provides care for patients with a variety of care needs, as detailed in section 3.0.

3.0 Service details

Organisation/Registered Provider: Mr Edward Maguire	**Registered Manager:** Ms Mary Catherine Powell
Person in charge at the time of inspection: Ms Mary Catherine Powell	**Date manager registered:** 10 June 2016
Categories of care: Nursing Homes (NH): I – Old age not falling within any other category. DE – Dementia. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. LD(E) – Learning disability – over 65 years. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 62 With a maximum number of patients accommodated in the following categories: NH-DE (8); NH-MP/MP(E) (4); NH-PH/PH(E) (2); NH-LD(E) (1); RC-LD (E) (1); RC-MP(E) (1)

4.0 Inspection summary

An unannounced inspection took place on 21 September 2017 from 09.40 to 13.50.

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 term ‘patients’ is used to describe those living in Greenpark, which provides both nursing and residential care.

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 medicine governance, medicine administration, medicine records, medicines storage and the management of controlled drugs.

No areas requiring improvement were identified.

The patients we spoke with were complimentary about the management of their medicines and the care provided 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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Mary Catherine Powell, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions required to be taken following the most recent inspection on 3 July 2017.

5.0 How we inspect

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

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of incidents; it was ascertained that no incidents involving medicines had been 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 three patients, the registered manager, three registered nurses, two members of care staff and one visiting speech and language therapist.

A total of 15 questionnaires were provided for distribution to patients, their representatives, and staff for completion and return to RQIA.

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 improvements 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 3 July 2017

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 19 July 2016

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:** Second time	The registered person must ensure that Seretide Evohalers are administered to patients in accordance with the prescribed instructions.	**Met**
	Action taken as confirmed during the inspection: Seretide Evohaler had been administered in accordance with the prescribed instructions.	

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 37 **Stated:** Second time	The recording system in place for all patients who are prescribed 'when required' anxiolytic and antipsychotic medicines should include detailed care plans and the documentation of the reason for and outcome of administration in the daily progress notes.	**Met**
	Action taken as confirmed during the inspection: The recording system in place for patients who were prescribed 'when required' anxiolytic and antipsychotic medicines included detailed care plans and the documentation of the reason for and outcome of administration in the daily progress notes.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered provider should ensure that discontinued controlled drugs are denatured and rendered irretrievable by two designated staff members on the premises and that two designated staff members witness the disposal of waste medicines.	**Met**
	Action taken as confirmed during the inspection: From examination of the controlled drugs record book and disposal of medicines record and from discussion with the nursing staff, it was evident that discontinued controlled drugs were denatured and rendered irretrievable by two designated staff members on the premises and that two designated staff members witnessed the disposal of waste medicines.	
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time	The registered provider should ensure that the Quality Improvement Plan is regularly reviewed as part of the quality improvement process, to ensure that all requirements and recommendations are fully addressed and the improvement sustained.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that the Quality Improvement Plan was regularly reviewed as part of the quality improvement process to ensure that all requirements and recommendations were fully addressed and the improvement sustained.	

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. 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 was provided in the last year.

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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medicine administration records were generally updated by two registered nurses. This safe practice was acknowledged.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Vulnerable adults training had been completed.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. 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. medicines administered through a feeding tube, 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 of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

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 arrangements in place to alert staff of when doses of weekly, monthly or three 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. 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 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. A pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment was completed as part of the admission process.

The management of swallowing difficulty was examined. Thickening agents were recorded on their personal medication record; however, details of the fluid consistency were not always specified. The registered manager gave an assurance that this matter would be addressed without delay. Administrations were 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 generally well maintained and facilitated the audit process. Areas of good practice were acknowledged. They include additional records for insulin, non-regular injection administration, opioid transdermal patches and warfarin. The registered manager gave an assurance that, where a patient had more than one personal medication record sheet in current use, this would be clearly highlighted on each sheet.

Practices for the management of medicines were audited throughout the month by the staff and management. In addition, a quarterly audit was completed by the community pharmacist. The dates of opening were recorded on most containers to facilitate audit activity; this good practice was acknowledged.

Following discussion with the registered manager and staff, 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 the GP practices and the Health and Social Care Trust.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

The administration of medicines to patients was completed in a caring manner; the patient was given time to take their medicines and medicines were administered as discreetly as possible.

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. From discussion and observation of staff, it was clear that they were familiar with the patients' needs, their likes and dislikes.

The patients we spoke with advised that they were content with the management of their medicines and the care provided in the home. One patient commented:

"I am happy and comfortable here."

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, we issued questionnaires to patients, patients' representatives and staff. No questionnaires were returned within the specified timeframe.

Areas of good practice

Staff listened to patients and took 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.

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 them.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

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.

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.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that management were open and approachable and willing to listen.

Areas of good practice

There were examples of good practice in relation to governance arrangements, 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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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