Unannounced Medicines Management Inspection Report
13 October 2016

Mahon Hall

Type of Service: Nursing Home
Address: 16 Mahon Road, Portadown, Craigavon, BT62 3EF
Tel no: 028 3835 0981
Inspector: Helen Mulligan

1.0 Summary

An unannounced inspection of Mahon Hall took place on 13 October 2016 from 9:25 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. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. Improvements are necessary in the management of records of controlled drugs and the storage of oxygen cylinders. One requirement and one recommendation 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. Two areas for improvement in relation to record keeping and the management of medicines for distressed reactions were identified. One requirement was made and a recommendation made at the previous medicines management inspection was stated 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. Patients consulted with confirmed that they were administered their medicines appropriately. There were no areas for 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 for 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.

Recommendations made as a result of this inspection relate to the 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 Mahon Hall which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Cheryl King, Acting 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 finance inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 12 November 2015.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/Dr Maureen Claire Royston	**Registered manager:** See box below
Person in charge of the home at the time of inspection: Ms Cheryl King	**Date manager registered:** Ms Cheryl King – Acting – no application required
Categories of care: NH-PH, RC-DE, RC-I, RC-PH, RC-PH(E), NH-I	**Number of registered places:** 60

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 five residents, one member of care staff, two registered nurses, the deputy manager and the acting manager of the home.

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.

The following records were 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 12 November 2015

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was returned and approved by the finance inspector. This QIP will be validated by the finance inspector at their next inspection.

4.2 Review of recommendations from the last medicines management inspection dated 9 September 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 18 **Stated:** First time	It is recommended that, if medication is prescribed on a "when required" basis for the management of distressed reactions, the reason for administration and the outcome should be recorded.	**Not Met**
	Action taken as confirmed during the inspection: This had not been addressed. The recommendation is 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 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.

The most recent training was in relation to the management of palliative care, thickening agents, dysphagia, subcutaneous fluids and PEG tubes and the application of creams.

Robust 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. Some overstocks of medicines were noted in the upstairs general unit; staff were reminded that robust ordering procedures should be in place to prevent any overstocks of medicines.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication 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.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. However, some records of the receipt of controlled drugs were incomplete and staff had not recorded the wastage when part-ampoules of controlled drugs were required to be administered. This must be addressed. A requirement was made. 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. The use of separate administration charts for warfarin was acknowledged. An insulin pen in use was not labelled and was not marked with the date of opening. Staff were reminded this should be addressed. Where medicines were required to be administered through enteral feeding tubes, authorisation to administer medicines via this route had been obtained from the prescriber. Staff were reminded that the method of administration of each medicine being administered via an enteral feeding tube should be detailed in the patient's care plan.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Medicine storage areas were clean, tidy and well organised. The majority of medicines were marked with the date of opening. Medicine refrigerators and oxygen equipment were checked at regular intervals. However, records showed that the refrigerator thermometer was not re-set each day; the manager confirmed that this would be addressed. Some oxygen cylinders in the home were not chained to the wall when not in use. This should be addressed. A recommendation was made. Staff in the dementia unit were reminded that the key to the controlled drugs cabinet should be kept separately from all other keys and this was addressed during the inspection. The manager was advised that the practice of storing supplements and thickening agents in unlocked cupboards in the dining room should be risk-assessed.

Areas for improvement

Records in the controlled drugs record book must be adequately maintained. A requirement was made.

Oxygen cylinders should be chained to the wall when not in use. A recommendation was made.

Number of requirements	1	Number of recommendations	1

4.4 Is care effective?

The sample of medicines examined indicated that the majority had been administered in accordance with the prescriber's instructions. However, a dose of a weekly medicine was omitted in error on 30 September 2016; this was reviewed with the prescriber immediately following the inspection. A significant discrepancy was also noted in the stock balance of an inhaler. One medicine was being given once daily; the hospital discharge stated that the medicines should be administered twice daily. This was reviewed in consultation with the prescriber on 14 October 2016; and the appropriate action was taken. The manager agreed that these medicines would continue to be closely monitored and any further discrepancies would be investigated and reported to RQIA.

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 was not recorded. A recommendation made at the previous medicines management inspection was stated for the second time. A care plan was maintained. One medicine prescribed on a "when required" basis was being administered on a regular basis. This was reviewed in consultation with the prescriber on 14 October 2016and the manager confirmed that the prescription was changed to a twice daily dosage.

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 care plan was maintained. Staff 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. 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. However, it was noted that frequent refusals of a prescribed eye drop had not been brought to the attention of the prescriber; the manager confirmed on 14 October 2016 by email that this had been reported to the prescriber.

Personal medication records were generally well-maintained, although care should be taken to ensure that units (e.g. mg) are clearly recorded. Records of the administration of medicines were sometimes illegible. This must be reviewed. A requirement was made.

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.

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

Areas for improvement

Where a medication is prescribed on a "when required" basis for the management of distressed reactions, the reason for administration and the outcome should be recorded. A recommendation was stated for the second time.

Records of the administration of medicines must be legible at all times. A requirement was made.

Number of requirements	1	Number of recommendations	1

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. Pain relief was offered during the medicine round. One patient requested pain relief and this was administered immediately.

Patients spoken to advised:

"I got my medicines today."
"I have no complaints."
"It couldn't be better 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.

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 reviewed on a regular basis. 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 audit records completed by staff in the home 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 not been addressed effectively. To ensure that any requirements and recommendations are fully addressed and improvements are sustained, it was suggested that the QIP should be regularly reviewed as part of the home's 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 in the home.

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 Cheryl King, Acting 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 the **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:** 14 November 2016	The registered provider must ensure that records in the controlled drugs record book are adequately maintained.
	Response by registered provider detailing the actions taken: This has been raised with staff in supervision and will be monitored by management on a weekly basis.
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 14 November 2016	The registered provider must ensure that records of the administration of medicines are legible.
	Response by registered provider detailing the actions taken: The manager has raised this with staff and has spoken to the staff nurse identified.
Recommendations	
Recommendation 1 **Ref**: Standard 18 **Stated:** Second time **To be completed by:** 14 November 2016	It is recommended that, if medication is prescribed on a "when required" basis for the management of distressed reactions, the reason for administration and the outcome should be recorded.
	Response by registered provider detailing the actions taken: This has been highlighted to staff again in supervision and management has spoken to the team leader regarding this. Management will monitor when completing care file audits.
Recommendation 2 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 14 November 2016	The registered provider should ensure that oxygen cylinders are chained to the wall when not in use.
	Response by registered provider detailing the actions taken: This has been completed for the identified cylinders on the first floor.

Please ensure this document is completed in full and returned to the web portal

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