Unannounced Medicines Management Inspection Report
6 June 2017

Mountvale

Type of Service: Nursing Home
Address: Brewery Lane, Meeting Street, Dromore, BT25 1AH
Tel No: 028 9269 9480
Inspector: Judith Taylor

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 51 beds that provides care for patients and residents living with old age and/or physical disability.

3.0 Service details

Registered organisation/registered provider: Mountvale Private Nursing Home Ltd **Responsible Individual:** Mr William Trevor Gage	**Registered manager:** Mrs Linda Kennedy
Person in charge of the home at the time of inspection: Senior Staff Nurse Mary Walsh until 11.15 and Mrs Linda Kennedy thereafter	**Date manager registered:** 18 June 2012
Categories of care: Nursing Home (NH): I - Old age not falling within any other category. PH - Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. Residential Care (RC): I - Old age not falling within any other category.	**Number of registered places:** 51 comprising: Maximum 7 in RC-I with one additional named resident in this category

4.0 Inspection summary

An unannounced inspection took place on 6 June 2017 from 10.00 to 15.35.

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.

The term ‘patients’ is used to describe those living in Mountvale, 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 the management of most medicine records, controlled drugs, medicine related incidents and arrangements for training.

Areas requiring improvement were identified in relation to the overall governance and auditing procedures in place for medicines management, the stock control and storage of medicines, and the management of records regarding thickening agents, distressed reactions and external preparations.

Patient comments included, “I am happy here,” “I can’t complain,” and, “They are good to you.”

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	1	3

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Linda Kennedy, Registered Manager, and Mr Trevor Gage, Responsible Individual, 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 finance inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 17 November 2016.

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 service was reviewed. This included the following records:

- 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

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

During the inspection we met with two patients, four registered nurses, the registered manager and the responsible individual.

A total of fifteen 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
- policies and procedures
- 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 17 November 2016

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 the next finance inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 2 September 2016

Areas for improvement from the last medicines management inspection		
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	In the instances where medicines are required to be administered in unlicensed form, the registered provider should ensure that written authorisation from the prescriber is in place.	**Met**
	Action taken as confirmed during the inspection: One medicine was administered in unlicensed form. Written details to crush the medicine were recorded on the medicine records and medicine label.	

Area for improvement 2 **Ref:** Standard 28 **Stated:** First time	The registered provider should develop a monitoring system which ensures that where patients are prescribed a daily fluid intake, the patient's fluid intake is monitored and recorded on a daily basis and that the target intake is achieved.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was identified in regard to management of enteral feeding fluid charts. The registered manager and staff confirmed that this had been reviewed at that time. However, there were no patients who required enteral feeding at the time of this inspection. Given these assurances this area for improvement was assessed as met.	
Area for improvement 3 **Ref:** Standard 28 **Stated:** First time	The registered provider should further develop the auditing process to ensure that the management of inhaled medicines and administration of calcium supplements and liquid medicines are closely monitored.	**Partially met**
	Action taken as confirmed during the inspection: The registered manager advised that the management of inhaled medicines had been closely monitored. However, there were no inhalers prescribed on a regular basis at the time of the inspection. In relation to calcium supplements, some of the audit trails produced satisfactory outcomes and there was evidence of monitoring. However, three calcium supplements could not be audited as the date of opening was not recorded and/or there was no record of the stock carried forward from the last medicine cycle. As written this area for improvement has been partially met. It has been incorporated into an area for improvement regarding the governance and auditing arrangements for medicines.	

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. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

The stock control of medicines was reviewed. There were systems in place to ensure that medicines were available for administration. One area for improvement was identified in relation to the medicine ordering processes. There were large excesses of medicines held in the overstock cupboard and stock was not being rotated. Medicines should only be ordered as the need arises.

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.

Robust arrangements were in place to manage changes to prescribed 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.

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.

The management of high risk medicines was examined. Robust arrangements were observed for the management of warfarin and insulin. Staff were reminded that discontinued warfarin regimes should be archived. However, for one injectable anticoagulant, the audit indicated the medicine had not been administered as prescribed. This was investigated by the registered manager and written details of the findings and corrective action taken was received by RQIA on 12 June 2017.

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

Most of the medicines were stored safely and securely and in accordance with the manufacturer's instructions. In relation to medicines with a limited shelf life once opened, the date of opening was recorded on most of these medicines; however, several eye preparations were removed from stock as these had passed the in use expiry date. The management of eye preparations should be included in the audit process. See Section 6.7.

Due to the excess stocks, there was limited capacity to store and readily access medicines. This should be reviewed. An area for improvement regarding stock control was identified above. Staff were reminded that sachets of lidocaine patches should be sealed at all times. 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 assessment, the management of medicines on admission and controlled drugs.

Areas for improvement

The stock control of medicines should be reviewed.

	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.

Of the sample of medicines which could be audited, largely satisfactory audit outcomes were achieved. However, several medicines which were not supplied in the 28 day blister packs could not be audited. The date of opening or stock level was not routinely recorded. This was discussed with staff and management and we were advised that this was the expected practice. It could not be determined if these medicines had been administered as prescribed. Advice was given. An area for improvement regarding audit was identified in Section 6.7.

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 or three monthly medicines were due.

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.

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. An area for improvement was identified, as it was noted that some of these medicines were administered on a regular basis and a care plan was not maintained for each patient prescribed these medicines.

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. Staff advised that most of the patients could verbalise any pain, and 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.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for high risk medicines and double signatures on personal medication records and administration records for new medicines. However, an area for improvement was identified in relation to external preparations and thickening agents. It was noted that where the administration of these medicines was delegated to care staff, the records were incomplete. A record of all administered medicines must be maintained.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record; however, details of the fluid consistency were not recorded. It was agreed that this would be added following the inspection. Care plans and speech and language assessment reports were in place.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to the patients' healthcare needs. A general practitioner visits the home on a weekly basis and includes a review of patients' medicines.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the standard of record keeping for most medicine records and care plans.

Areas for improvement

The management of distressed reactions should be reviewed to ensure that a care plan is maintained for each patient and any regular administration is referred to the prescriber. A system should be implemented to ensure that records of the administration of external preparations and thickening agents are closely monitored.

	Regulations	Standards
Total number of areas for improvement	0	2

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, patients were 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. It was clear that the staff were familiar with the patients' needs, their likes and dislikes.

The patients spoken to had no concerns regarding the management of their medicines and advised that staff responded in a timely manner to any requests for pain relief. They were complimentary about the staff and the care provided in the home.

Fifteen questionnaires were left in the home to facilitate feedback from patients, staff and relatives. Four were returned within the time frame from staff who advised that they were very satisfied/ satisfied with all aspects of the care in relation to the management of medicines.

Areas of good practice

Staff listened to patients and relatives 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. These were not examined in detail. 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. 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.

The systems in place to audit the management of medicines were reviewed. Although there was evidence of some auditing, there was limited evidence that individual medicines were being audited. This was discussed in relation to the inspection findings. As there were areas for improvement identified in the domains of safe and effective care, a robust auditing system should be developed and implemented.

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 staff spoke positively about their work and the support provided within the home. They advised that management were approachable and willing to listen and confirmed that any concerns in relation to medicines management were raised with management.

One of the areas for improvement identified at the last medicines management inspection was not addressed appropriately. To ensure that this is fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the management of medicine incidents and communication with staff.

Areas for improvement

The governance arrangements for medicines should be reviewed to ensure that all aspects of medicines management are included in the audit process.

	Regulations	Standards
Total number of areas for improvement	1	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 Mrs Linda Kennedy, Registered Manager, and Mr Trevor Gage, Registered Provider, 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 QIP to pharmacists@rqia.org.uk for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 6 July 2017	The registered person shall develop and implement a robust auditing process which covers all aspects of medicines management. **Ref: 6.7**
	Response by registered person detailing the actions taken: The Auditing Process has been increased and is more robust covering all aspects of Medication Management
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 28 **Stated:** First time **To be completed by:** 6 July 2017	The registered person shall review the stock control processes for medicines to ensure that stock is only ordered as the need arises. **Ref: 6.4**
	Response by registered person detailing the actions taken: Trained staff meeting held to discuss above and meeting held with local Pharmacist to ensure only stock that is required is ordered.
Area for improvement 2 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 6 July 2017	The registered person shall review the management of distressed reactions to ensure that a care plan is maintained for the relevant patients and any regular administration is referred to the prescriber. **Ref: 6.5**
	Response by registered person detailing the actions taken: Patient identified on day of Inspection has now got a care plan in place is now prescribed the medication on a regular basis.
Area for improvement 3 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 6 July 2017	The registered person shall review the administration of medicines by care staff to ensure the records are fully maintained. **Ref: 6.5**
	Response by registered person detailing the actions taken: Meeting held with senior care staff to discuss above and extra time has been allocated for records to be monitored and audited.

Please ensure this document is completed in full and returned pharmacists@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews