Unannounced Medicines Management Inspection Report
15 August 2016

Our Mother of Mercy

Service Type: Nursing Home
Address: 1 Home Avenue, Newry, BT34 2DL
Tel No: 028 3026 2086
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Our Mother of Mercy took place on 15 August 2016 from 10.10 to 14.30.

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 some areas of the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff were trained and competent. However improvements in the management of medication changes were necessary. One requirement was made.

Is care effective?

There was evidence that the management of medicines supported the delivery of effective care for patients. There were systems in place to ensure that patients were administered their medicines as prescribed. Satisfactory arrangements were in place for the management of pain. One recommendation in relation to the management of distressed reactions was made.

Is care compassionate?

There was evidence that the management of medicines supported the delivery of compassionate care. Staff interactions with patients were observed to be compassionate, caring and timely. No requirements or recommendations were made.

Is the service well led?

There was evidence that the service was well led with respect to the management of medicines. Written medicine policies and procedures were in place. There were robust systems to manage and share the learning from medication audits. No requirements or recommendations were made.

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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Our Mother of Mercy which provides both nursing and residential care.

1.1 Inspection outcome

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

Details of the QIP within this report were discussed with Miss Kerrie-Ann McNamee, Nurse in Charge, and Mrs Peggy O'Neill, Registered Provider, 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 care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the inspection on 16 May 2016.

2.0 Service details

Registered organisation/registered person: Kilmorey Care Ltd Mrs Peggy O'Neill	**Registered manager:** Mrs Elizabeth Doran
Person in charge of the home at the time of inspection: Miss Kerrie-Ann McNamee (Registered Nurse)	**Date manager registered:** 4 November 2013
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E), RC-I, RC-MP, RC-MP(E), NH-LD, NH-LD(E)	**Number of registered places:** 48

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; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We spoke with four patients, one care assistant, three registered nurses and the registered provider.

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 16 May 2016.

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

4.2 Review of requirements and recommendations from the last medicines management inspection dated 14 December 2015

There were no requirements of recommendations made as a result of the last medicines management inspection.

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 supervision and annual appraisal. Competency assessments were completed annually. Training on the home's new medication recording system had been provided in the last year.

All medicines were available for administration as prescribed on the day of the inspection. There was no evidence that medicines had been out of stock. The nurse in charge confirmed that robust systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. She confirmed that the registered manager was made aware of any potential shortfalls in medicines.

The home had implemented a new computerised recording system. Personal medication records and medication administration records were reprinted and checked by two registered nurses each time that there was a change in prescribed medication. However, it was noted that one medicine that had been discontinued on 5 August 2016 had not been removed from the trolley and staff were unable to confirm if the medication had been administered. This was investigated following the inspection and an incident report was forwarded to RQIA. In addition two supplies of two medicines were in use for this patient therefore a clear audit trail was not available. 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.

Mostly satisfactory arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged. However, it was noted that the date of opening had not been recorded on some in-use insulin pens and dosage directions had been abbreviated. The registered provider confirmed that this had already been highlighted to all registered nurses. She advised that it would be discussed again and monitored through the audit process.

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 for improvement

The registered provider must review and revise the management of medication changes to ensure that discontinued medicines are removed from the trolley and that only one supply of each medicine is available for administration. A requirement was made.

Number of requirements	1	Number of recommendations	0

4.4 Is care effective?

With the exception of the three medicines discussed in Section 4.3 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. However, detailed care plans were not in place for all patients, and the reason for and the outcome of administration were not being recorded on all occasions. A recommendation was made.

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. The nurse in charge advised that a pain assessment is completed as part of the admission process and that it was reviewed monthly or more frequently if necessary. A pain tool was used for those patients who could not verbalise their pain. Care plans were observed to be in place.

The management of swallowing difficulty was examined. Care plans and speech and language assessment reports were in place. Thickening agents were recorded on the personal medication records and included details of the fluid consistency. Registered nurses recorded administration on the medication administration records. Care assistants recorded each administration on the computerised system. For one patient the required fluid consistency had not been updated on the records following a recent review. This further highlighted the need for a more robust system for managing dosage changes as discussed in Section 4.3.

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. For some patients family members assist with the administration of medicines if the patients are non-compliant. Care plans for this were in place. However, registered nurses were recording that they had administered the medicines. This was discussed in detail with the registered provider, nurse in charge and one other registered nurse. It was agreed that the records of administration would detail accurately who had administered the medication from the day of the inspection onwards.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the additional recording sheets 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 medicines which were not contained within the monitored dosage system. In addition, a quarterly audit was completed by the community pharmacist. The nurse in charge was due to complete an audit on the day of the inspection.

Following discussion with the nurse in charge it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas for improvement

The registered provider should review and revise the management of distressed reactions to ensure that detailed care plans are in place. The reason for and outcome of each administration should be recorded. A recommendation was made.

Number of requirements	0	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.

We spoke with two patients. They confirmed that they could request additional pain relief if required and that "staff could not be kinder".

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. 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. The nurse in charge confirmed that management would be made aware of any incidents which would then be investigated and action plans to prevent a recurrence implemented. It was noted that there had been a delay in the administration of an opioid transdermal patch for one patient on two occasions since 18 June 2016. This had been investigated and prompts to remind staff had been put in place. The registered provider confirmed that the patient had not experienced any pain. This type of incident should be reported to RQIA and this was discussed. As these incidents had been appropriately managed in the home and an incident report was forwarded to RQIA on the day after the inspection a requirement was not made on this occasion.

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 provider, 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 any resultant action was communicated with all staff either individually or through staff meetings.

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

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Peggy O'Neill, Registered Provider, and Miss Kerrie-Ann McNamee, Nurse in charge, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. 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 person/s 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 DHSSPS Care Standards for Nursing Homes (2015). They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to pharmacists@rqia.org.uk and assessed 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 person/manager 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 person/manager 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 September 2016	The registered provider must ensure that discontinued medicines are removed from the trolley and that only one supply of each medicine is available for administration.
	Response by registered person detailing the actions taken: All nurses have been instructed to insure that all discontinued medicines are removed from the trolley and only have one supply of medication available.
Recommendations	
Recommendation 1 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 14 September 2016	The registered provider should review and revise the management of distressed reactions to ensure that detailed care plans are in place. The reason for and outcome of each administration should be recorded.
	Response by registered person detailing the actions taken: All nurses have been instructed to ensure a detailed care plan is in place for distressed reactions and recorded in evauation reason and outcome - this will be checked when audits are being carried out.

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

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