Unannounced Medicines Management Inspection Report
18 October 2016

St Josephs

Type of Service: Nursing Home
Address: 16 Princes Street, Warrenpoint, Newry, BT34 3NH
Tel no: 028 4175 3572
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of St Joseph's took place on 18 October 2016 from 10.20 to 13.30.

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 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. There were no areas of improvement identified.

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 of improvement were identified in relation to the management of distressed reactions and records of receipt of medicines. Two recommendations were made.

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 of 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 of 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.

For the purposes of this report, the term 'patients' will be used to described those living in St Joseph's which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Jacqueline Rooney, 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.

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 most recent inspection on 15 September 2016.

2.0 Service details

Registered organisation/registered person: Kilmorey Care Ltd/Mrs Peggy O'Neill	**Registered manager:** Mrs Jacqueline Rooney
Person in charge of the home at the time of inspection: Mrs Jacqueline Rooney	**Date manager registered:** 29 April 2008
Categories of care: NH-LD, NH-I, NH-LD(E), NH-PH, NH-PH(E), RC-I, RC-PH, RC-PH(E)	**Number of registered places:** 50

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 spoke to two patients, two registered nurses, the registered manager and the registered person.

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.

A sample of the following records was examined:

- medicines requested and received
- personal medication records
- medicine administration records (MARs)
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- care plans
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 15 September 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP is due for return on 1 November 2016. This QIP will be validated by the care inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection 12 May 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** Second time	The registered manager must ensure a robust audit system is implemented and completed regularly.	**Met**
	Action taken as confirmed during the inspection: The audit system is robust and consists of a monthly audit by the registered manager and a quarterly audit by the community pharmacist. An action plan is produced and implemented by staff.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 38 **Stated:** First time	The registered manager should ensure that the record of medicines disposed of is fully and accurately maintained.	**Met**
	Action taken as confirmed during the inspection: A record was made of all medicines that were disposed of. Staff were reminded that this record should be signed by two staff members. The registered manager advised that this would be done from the day of the inspection onwards.	

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 the management of medicines 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.

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. 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 and insulin. The use of separate administration charts was acknowledged.

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 and tidy. 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. Staff were reminded that oxygen cylinders should be securely chained and the oxygen masks covered in accordance with infection control guidance.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

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.

During the inspection, it was noted that three patient's medicines were stored in cups on the medicines trolley. These medicines had been dispensed but refused by the patients. The nurses explained that they were going to return to the patients after breakfast to enquire if they wanted to take the medicines. Storage of medicines like this on the trolley may lead to an error in the administration. This was discussed with the registered manager who agreed to review this with staff.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the 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, specific dosage instructions had not been recorded on the personal medication record, there was no care plan on file and the reason for and the outcome of administration had not been recorded. The management of distressed reactions should be reviewed and revised. 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. Staff advised that most of the patients could verbalise any pain. Following a recent audit, a pain assessment tool was to be implemented. A care plan was maintained.

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 well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included good recording of the quantity of medicines carried forward from one cycle to the next and good use of codes for non-administration. However, when more than one MARs sheets were in use, the patient's name was not always recorded on all sheets. The registered manager advised by telephone on 19 October 2016 that this issue had been resolved.

The record of receipt of medicines for patients following admission from hospital should be reviewed. These records were not always made. The registered manager should ensure that records of receipt of medicines are fully and accurately maintained. A recommendation was made.

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

Areas for improvement

The registered manager should ensure that management of distressed reactions is reviewed and revised to ensure that all of the appropriate records are maintained. A recommendation was made.

The registered manager should ensure that records of receipt of medicines are fully and accurately maintained. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

The administration of medicines to one patient was observed during the inspection. The nurse administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to swallow each medicine.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients were treated courteously, with dignity and respect. Good relationships were evident.

The patients spoken to said that they had no concerns in relation to the management of their medicines and were very complimentary about 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?

The registered manager advised that written policies and procedures for the management of medicines were in place. They were not examined during this inspection. 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.

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.

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 Mrs Jacqueline Rooney, Registered 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

Recommendations	
Recommendation 1 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 18 November 2016	The registered manager should ensure that management of distressed reactions is reviewed and revised to ensure that all of the appropriate records are maintained.
	Response by registered provider detailing the actions taken: A record is in place alongside each residents administraion sheet for those who are on medication as required for distressed reaction and a care plan in place to manage same
Recommendation 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 18 November 2016	The registered manager should ensure that records of receipt of medicines are fully and accurately maintained.
	Response by registered provider detailing the actions taken: Reciept of all medicines is recorded on the residents Admininistration sheet and a second record is mainatined for all controlled drugs

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

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