Unannounced Medicines Management Inspection Report
9 June 2016

St Macartans

Type of Service: Nursing Home
Address: 74 Main Street, Clogher, BT76 0AA
Tel No: 028 8554 8250
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of St Macartans took place on 9 June 2016 from 09:30 to 13:25.

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?

The management of medicines supported the delivery of safe care. 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. 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 recommendations have been made relating to the development of care plans for pain management and the recording of the fluid consistency of thickening agents.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely. 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.

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 St Macartans 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 QIP within this report were discussed with Mrs Noreen Monaghan, Nurse 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 previous QIP there were no further actions required to be taken following the last inspection on 14 January 2016.

2.0 Service details

Registered organisation/registered provider: Kilmorey Care Ltd / Mrs Peggy O'Neill	**Registered manager:** See box below
Person in charge of the home at the time of inspection: Mrs Noreen Monaghan (Nurse Manager)	**Date manager registered:** Mrs Noreen Monaghan - application received - "registration pending"
Categories of care: NH-LD, NH-LD(E), RC-LD, RC-LD(E), NH-DE, NH-I, NH-PH, NH-PH(E), RC-I	**Number of registered places:** 33

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned medicines management QIP
- recent correspondence with the home

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

During the inspection, the inspector met with three patients, the nurse manager, one registered nurse and one care assistant.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity.

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 14 January 2016

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 their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 27 April 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 28 **Stated:** First time	It is recommended that the registered person should ensure the reason for and outcome of administration of a medicine prescribed on a "when required" basis for the management of distressed reactions are always recorded.	**Met**
	Action taken as confirmed during the inspection: The reason for and outcome of administration of medicines prescribed on a "when required" basis for the management of distressed reactions were recorded.	

4.3 Is care safe?

Medicines were managed by staff who had 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 general medicines management was provided within the last year. Staff had also attended training in relation to eating and swallowing difficulties, enteral tube feeding and pain management in palliative care.

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.

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin.

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 manufacturers' 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

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, two 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. There were two instances where patients were being regularly administered medication which was prescribed for administration on a "when required" basis; the nurse manager gave an assurance that the prescribers would be requested to review the dosage directions.

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 a pain assessment was completed as part of the admission process and that a pain tool was used as needed. A care plan was not maintained; a recommendation was made.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record; however, it did not include details of the fluid consistency. For one patient, the fluid consistency had been inaccurately recorded on their medicine administration record since 6 June 2016. Another patient did not have the fluid consistency recorded on their care plan. A recommendation was made. Each administration was recorded 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 mostly well maintained and facilitated the audit process. Areas of good practice were acknowledged.

They included additional records for antibiotic courses, transdermal patches and warfarin. Personal medication records were not updated by two registered nurses; the manager gave an assurance that this matter would be rectified.

Practices for the management of medicines were audited throughout the month by the management and registered nurses. This included running stock balances for antibiotics, analgesics and warfarin. The dates and times of opening of the medicine containers were recorded in order to facilitate audit; this was acknowledged as good practice. In addition, a quarterly audit was completed by the community pharmacist and a report of the outcome provided to management.

Following discussion with the nurse manager and registered nurse and a review of care files, it was evident that, when applicable, other healthcare professionals were contacted in response to issues or concerns in relation to medicines management.

Areas for improvement

A care plan should be in place for each patient prescribed pain relief medication. A recommendation was made.

The fluid consistency of thickening agents should be fully and accurately recorded on all relevant records. A recommendation was made.

Number of requirements:	0	Number of recommendations:	2

4.5 Is care compassionate?

The administration of medicines to several patients at lunchtime was observed during the inspection. The medicines were administered to the patients in the dining room. The registered nurse administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to swallow each medicine. Extra time and attention was given to patients who had difficulty swallowing some of the medicines. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

The patients spoken to advised that they had no concerns in relation to the management of their medicines, and their requests for medicines prescribed on a “when required” basis was adhered to e.g. pain relief.

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 knowledgeable of these policies and procedures and that any updates were highlighted to them by management.

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 internal audit records indicated that satisfactory outcomes had been achieved.

Following discussion with the nurse manager and registered nurse, 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 this QIP were discussed with Mrs Noreen Monaghan, Nurse 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 DHSSPS 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 taken by the registered manager/registered person

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP 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 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 4 **Stated:** First time **To be completed by:** 9 July 2016	The registered provider should ensure that a care plan is in place for each patient prescribed pain relief medication. **Response by registered person detailing the actions taken:** All patients on P.R.N prescribed medication have had their medications reviewed by their GP'S and these medications are now prescribed and administered on a regular basis and recorded accordingly. A care plan is in place for every patient prescribed pain relief medication.
Recommendation 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 9 July 2016	The registered provider should ensure that the fluid consistency of thickening agents is fully and accurately recorded on all relevant records. **Response by registered person detailing the actions taken:** A proforma is in place for every patient prescribed and using thickening agents. This is recorded on the drug Kardex and on the Goldcrest system.

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

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