Unannounced Medicines Management Inspection Report
26 June 2017

St Macartans

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

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 33 beds that provides care for patients of old age with dementia, learning disability or physical disability.

3.0 Service details

Registered organisation: Kilmorey Care Ltd **Responsible Individual:** Mrs Peggy O'Neill	**Registered manager:** Mrs Noreen Monaghan
Person in charge of the home at the time of inspection: Mrs Noreen Monaghan	**Date manager registered:** 28 September 2016
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. LD – Learning disability. LD(E) – Learning disability – over 65 years. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. Residential Care (RC) LD – Learning disability. LD(E) – Learning disability – over 65 years. I – Old age not falling within any other category.	**Number of registered places:** 33 A maximum of 8 patients in category NH-DE. A maximum of 6 persons accommodated within categories NH-LD/LD(E), RC-LD/LD(E). The home is also approved to provide care on a day basis to 1 person in the dementia unit.

4.0 Inspection summary

An unannounced inspection took place on 26 June 2017 from 09.35 to 12.50.

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 St Macartans, 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 medicine administration, medicine records, storage and the management of controlled drugs.

Areas requiring improvement were identified regarding the maintenance of personal medication records and care planning for patients prescribed medication for administration on a "when required" basis for the management of distressed reactions.

Patients were complimentary regarding the management of their medicines and the care provided.

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	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Noreen Monaghan, 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.

4.2 Action/enforcement taken following the most recent premises inspection

No actions were required to be taken following the most recent inspection on 13 April 2017. 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:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of incidents; it was ascertained that no incidents involving medicines had been 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, the registered manager, one registered nurse and three care staff.

A total of 15 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
- care plans
- training records
- medicines storage temperatures

Areas for improvements 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 13 April 2017

The most recent inspection of the home was an unannounced premises inspection. There were no areas for improvement made as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 09 June 2016

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 4

Stated: First time</td><td>The registered provider should ensure that a care plan is in place for each patient prescribed pain relief medication.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
For two patients whose records were examined, pain management care plans were in place.</td></tr>
</table>

Area for improvement 2 **Ref**: Standard 29 **Stated:** First time	The registered provider should ensure that the fluid consistency of thickening agents is fully and accurately recorded on all relevant records.	**Met**
	Action taken as confirmed during the inspection: For two patients whose records were examined, the fluid consistency of thickening agents were fully and accurately recorded on all relevant records.	

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 last provided in February 2016. The most recent training was in relation to dysphagia.

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. 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.

There were generally satisfactory arrangements in place to manage changes to prescribed medicines. However, as stated in section 6.5, new medicine entries personal medication records had not been verified and signed by two designated staff.

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

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. However, as stated in section 6.5, personal medication records had not been verified and signed by two designated staff when they were brought into use.

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. medicines administered by the enteral route and insulin.

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. The medicine refrigerator and oxygen equipment were checked at regular intervals.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessments and controlled drugs.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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 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, for the two patients whose records were examined, care plans were not maintained; an area for improvement was identified.

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 tool was used as needed. A care plan was maintained. Staff also 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. Administrations were 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.

Medicine records were maintained in a mostly satisfactory manner and facilitated the audit process. Areas of good practice were acknowledged. The use of separate administration records for analgesics, antibiotics, insulin and transdermal opioid patches was acknowledged. However, most personal medication records had not been verified and signed by two designated staff when they were brought into use and when changes to prescribed medicines had occurred. Also, the route of application of eye preparations were generally not recorded on the personal medication record sheets. Two areas for improvement were identified.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for analgesics and antibiotics. 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 periodic audit was completed by the community pharmacist and a report of the outcome provided to management.

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. Staff on duty advised that they had good working relationships with the community pharmacy, GP practices and the Health and Social Care Trust.

Areas of good practice

There were examples of good practice in relation to the administration of medicines and the maintenance of medicine records.

Areas for improvement

Areas for improvement were identified in relation to the maintenance of personal medication records and care planning for patients prescribed medication for administration on a "when required" basis for the management of distressed reactions.

	Regulations	Standards
Total number of areas for improvement	0	3

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.

Patients spoken with advised that they were satisfied with the care provided. 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.

As part of the inspection process, we issued questionnaires to patients, patients' representatives and staff. Four patients and two patient's representatives completed and returned questionnaires within the specified timeframe. Comments received were positive; the responses were recorded as 'very satisfied' or 'satisfied' with the management of medicines in the home.

Five members of staff also completed a questionnaire. The responses were positive and raised no concerns about the management of medicines in the home.

Areas of good practice

Staff listened to patients 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. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report 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.

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 nurse 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 of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	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 Noreen Monaghan, Registered Manager, 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 Web Portal 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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 26 July 2017	The registered person shall ensure that each patient who is prescribed medication for administration on a "when required" basis for the management of distressed reactions has a care plan that includes details regarding the use of the medication. Ref: 6.5
	Response by registered person detailing the actions taken: There is a care plan in place that includes details of the use of PRN medication for all patients who are prescribed medication for administration on a when required basis for the management of distressed reactions. Completed on 01/07/17
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 26 July 2017	The registered person shall ensure that personal medication records are verified and signed by two designated staff when they were brought into use and when changes to prescribed medicines have occurred. Ref: 6.5
	Response by registered person detailing the actions taken: All personal medication records are verified and signed by two designated staff when they were brought into use and when changes to prescribed medications have occured. Completed on 01/07/17
Area for improvement 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 26 July 2017	The registered person shall ensure that the route of application of eye preparations is recorded on the personal medication record sheets. Ref: 6.5
	Response by registered person detailing the actions taken: All application of eye preparations are recorded to ensure the route and to which eye is clear and signed by 2 designated staff. Completed on 01/07/17

Please ensure this document is completed in full and returned via Web Portal