Unannounced Medicines Management Inspection Report
11 December 2017

Greenvale House

Type of Service: Nursing Home
Address: 82-84 Mill Hill, Castlewellan, BT31 9NB
Tel No: 028 4377 8280
Inspector: Helen Daly

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 43 beds that provides care for patients and residents with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Greenvale House **Responsible Individuals:** Mrs Barbara Frances Foster Mrs Margaret Foster Mr Norman Foster	**Registered Manager:** See box below
Person in charge at the time of inspection: Mrs Donna Rogan, Manager	**Date manager registered:** Mrs Donna Rogan, registration pending
Categories of care: Nursing Homes (NH) I – old age not falling within any other category DE – dementia PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years LD(E) – learning disability – over 65 years Residential Care (RC) I – old age not falling within any other category DE – dementia	**Number of registered places:** 43 comprising: 32 nursing 11 residential A maximum of nine persons in category RC-DE and one named person in category NH-LD (E). The home is also approved to provide care on a day basis for one person.

4.0 Inspection summary

An unannounced inspection took place on 11 December 2017 from 10.30 to 16.00.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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 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.

The term ‘patients’ is used to describe those living in Greenvale House which at this time provides both nursing and residential care.

Evidence of good practice was found in relation to medicines administration, storage and the management of controlled drugs.

Areas requiring improvement were identified in relation to the management of medicines on admission/re-admission to the home, the management of medication changes and the standard of maintenance of the personal medication records and medication administration records.

The patients and relatives we spoke with were complimentary about the management of their medicines and the care provided in the home.

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	2	*1

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Donna Rogan, Manager, and Mrs Barbara Foster, 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 care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 11 May 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 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 three patients, two relatives, three care staff, three registered nurses and the management team.

A total of 10 questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

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 11 May 2017

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 the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 14 December 2016

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered provider must ensure that complete records for the administration of thickening agents are maintained.	**Met**
	Action taken as confirmed during the inspection: Registered nurses recorded administration on the medication administration recording sheets. A list of the recommendations for each patient was available for all care staff. Following the last inspection the daily meals and snacks booklets were amended to enable care staff to record each administration. However, this section was not currently being completed. Following discussion with care staff they confirmed that fluids were being thickened and administered as prescribed. The manager advised that this would be discussed with all care staff for immediate action and monitored closely as part of the home's auditing procedures. Due to the assurances provided this area for improvement has been assessed as met.	
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 29 **Stated:** First time	The registered provider should ensure that hand-written updates/entries on the medication administration records (MARs) are verified and signed by two registered nurses.	**Not met**
	Action taken as confirmed during the inspection: The majority of hand-written updates/entries on the medication administration records (MARs) had not been verified and signed by two registered nurses. This area for improvement was stated for the second time.	

Area for improvement 2 **Ref:** Standard 29 **Stated:** First time	The registered provider should ensure that obsolete warfarin and insulin dosage directions are cancelled and archived.	**Met**
	Action taken as confirmed during the inspection: Obsolete warfarin and insulin dosage directions had been cancelled and archived.	

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.

The manager confirmed that medicines were managed by registered nurses who had been trained and deemed competent to do so. As the manager was new to her position competency assessments were being completed with all registered nurses. Part of the nursing home is in the process of being registered as a separate residential care home; care assistants were currently being trained to manage medicines. Update training on medicines management had been requested from the community pharmacist; this was planned to be carried out in January 2018.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. There was evidence that 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.

The procedures in place to ensure the safe management of medicines during a patient's admission to the home were unsatisfactory. For one recently admitted patient their current medication regimen had not been confirmed with the prescriber. For a second patient (who had been re-admitted from hospital) there had been a delay in updating the personal medication record. This led to three medicines being administered for up to five days after they had been discontinued. The registered manager reported this to the general practitioner during the inspection for guidance. An area for improvement was identified.

The management of medication changes was unsatisfactory. Personal medication records and handwritten entries on medication administration records had not been updated by two registered nurses. This area for improvement on the medication administration records had been identified at the last medicines management inspection and was therefore stated for a second time. As there were other issues with the personal medication records, this area for improvement has been discussed further in Section 6.5.

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 for insulin 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, 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. As had been identified at the last medicine management inspection, some temperatures outside the accepted range were observed for the medicines refrigerator; guidance on resetting the thermometer was provided for the management team. They agreed that this would be closely monitored.

Areas of good practice

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

Areas for improvement

Robust systems must be in place for the management of medicines on admission/re-admission to the home and the management of medication changes. Current medication regimens should be received in writing. Personal medication records and medication administration records should be written /updated by two registered nurses. Discontinued medicines must be removed for disposal without delay.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

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

With the exception of the three medicines discussed in Section 6.4, 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.

A small number of patients were prescribed a medicine for administration on a "when required" basis for the management of distressed reactions. Dosage directions were clearly recorded on the personal medication records and care plans were in place. The reason for and the outcome of administration were observed to be recorded in the daily progress notes. 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 sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff advised that a pain assessment tool was used with those patients who could not verbalise their pain. We observed one care plan to be missing; the registered manager advised that this was an oversight and that it would be addressed.

For those patients prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Care plans and speech and language assessment reports were in place. A list of each patient's recommendations was available for care staff and a system to record each administration was in place. However, as detailed in Section 6.2 care staff were not recording each administration. It was agreed that this would be reviewed with all care staff and closely monitored by the management team.

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.

Examination of the personal medication records indicated that several needed to be re-written due to the large number of changes that had been recorded. The following improvements on the personal medication records were required:

- they should be up to date
- all currently prescribed medicines and dosage directions should be clearly recorded
- updates should be verified and signed by two registered nurses, in a timely manner
- where possible only one record should be in place for each patient; the record should be re-written when there have been several changes
- they should correlate with the pre-printed medication administration records

An area for improvement was identified.

Following discussion with the management and staff, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in patient care.

Areas of good practice

There were examples of good practice in relation to care planning and the administration of medicines.

Areas for improvement

The personal medication records should be up to date and reflect the prescribers' most recent directions. Entries should be verified and signed by two registered nurses. Dosage directions should be clearly recorded. As stated in Section 6.7, the standard of maintenance of the personal medication records should be included in the home's audit processes.

	Regulations	Standards
Total number of areas for improvement	1	0

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.

We observed the administration of medicines to a number of patients. The registered nurses administering the medicines spoke to the patients in a kind and caring manner and the patients were given time to swallow their medicine. However, it was noted that medicines were administered during lunch; the manager advised that this would be reviewed.

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 from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes.

Relatives spoken to during the inspection were complimentary about the staff and care provided. One relative suggested that more activities may be beneficial and this was discussed with the management for review.

As part of the inspection process, we issued ten questionnaires to patients and their representatives. Two were completed and returned within the specified timeframe. Comments received were positive; with responses recorded as 'very satisfied' or 'satisfied' with the care provided in the home.

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.

The manager was new to her position, she advised that she was currently reviewing and updating the home's policies and procedures, including those for the management of medicines. She advised that she had identified the need to make improvements in the governance arrangements and drive improvements in some areas of medicines management.

There were robust arrangements in place for the management of medicine related incidents. Medicine related incidents reported since the last medicines management inspection were discussed; there was evidence of the action taken and learning implemented.

In relation to the regional safeguarding procedures, the manager confirmed that staff were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the home's auditing system indicated that it did not include all aspects of medicines management. This was discussed in detail with management; it was agreed that a robust auditing system would be implemented to include all aspects of the management of medicines, including the standard of maintenance of the personal medication records, the admission process, the management of medication changes and the management of thickening agents. As one area for improvement identified at the last medicines management inspection had not been addressed effectively, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Following discussion with the care staff, registered nurses and management, 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 management were open and approachable and willing to listen.

Areas of good practice

There were examples of good practice in relation to management of medication incidents. 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 Barbara Foster, Registered Manager, and Mrs Donna Rogan, 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 via Web Portal for assessment by the inspector.

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:** 11 January 2018	The registered person shall ensure that there are robust systems in place for the management of medicines on admission/re-admission to the home. Ref: 6.4
	Response by registered person detailing the actions taken: There are more robust measures now in place. Auditing includes the management of medicines on admission/re-admission to the home. All trained staff are now aware of the procedure regarding medicines on admission and re-admission.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 11 January 2018	The registered person shall ensure that personal medication records are up to date and contain all the necessary detail. Ref: 6.4 and 6.5
	Response by registered person detailing the actions taken: All medicine kardex have been re-written and are up to date. They all contain the necessary detail.
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 29 **Stated:** Second time **To be completed by:** 11 January 2018	The registered provider should ensure that hand-written updates/entries on the medication administration records (MARs) are verified and signed by two registered nurses. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken: Two registered nurses now sign the MARs sheet. This has been monitored by the home manager.

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

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