Unannounced Medicines Management Inspection Report
14 December 2016

Greenvale House

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

1.0 Summary

An unannounced inspection of Greenvale House took place on 14 December 2016 from 10.15 to 15.15.

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. Two areas for improvement in relation to records management were identified. Two recommendations were made.

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. One area of improvement was identified in relation to records for the administration of thickening agents. A requirement was 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. 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 Greenvale House which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	2

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

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 9 June 2016.

2.0 Service details

Registered organisation/registered person: Mr Norman Foster Mrs Margaret Foster Mrs Barbara Frances Foster	**Registered manager:** Mrs Barbara Frances Foster
Person in charge of the home at the time of inspection: Mrs Barbara Frances Foster	**Date manager registered:** 1 April 2005
Categories of care: RC-I, NH-DE, NH-I, NH-PH, NH-PH(E), RC-DE, RC-LD(E)	**Number of registered places:** 43

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 met with three care staff, one registered nurse and the registered manager.

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 number of questionnaires were issued to patients, relatives/patients' representatives and staff, with a request that they were returned within one week from the date of the inspection.

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 9 June 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 28 May 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref: Standard 26** **Stated: First time**	It is recommended that training is undertaken to ensure that staff can use a formal pain assessment tool to ascertain if residents with dementia are in pain and respond effectively to the need for pain relief.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that training on the management of pain in patients with dementia was provided following the last medicines management inspection. A pain assessment tool was being used. Care plans for the management of pain were in place and there was evidence that 'when required' analgesics were being used.	
Recommendation 2 **Ref: Standard 26** **Stated: First time**	It is recommended that care plans to direct the management of distressed behaviours and the assessment and relief of pain should be in place.	**Met**
	Action taken as confirmed during the inspection: Care plans to direct the management of distressed behaviours and the assessment and relief of pain were in place.	

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. Competency assessments were completed annually. The registered manager advised that refresher training had been requested from the community pharmacist and that she had plans to complete in-house training on medicines management.

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 mostly satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses. This safe practice was acknowledged. However, handwritten entries on medication administration records had not been signed by two registered nurses. A recommendation 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. However, one medicine had not been administered for 12 days following a review by the general practitioner. The registered manager was requested to investigate this discrepancy, inform the general practitioner, family and care management. The outcome of the investigation including an action plan to prevent a recurrence was received by RQIA on 2 January 2017.

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, obsolete warfarin facsimiles and insulin directions had not been cancelled and archived. A recommendation was made. Staff were reminded that insulin pens should be discarded four weeks after opening.

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 e.g. eye preparations, once opened. Medicine refrigerators and oxygen equipment were checked at regular intervals. A number of medicine refrigerator temperatures outside the accepted range were observed; the registered manager advised that records would be closely monitored.

Areas for improvement

The registered provider should ensure that hand-written updates/entries on the medication administration records (MARs) are verified and signed by two registered nurses. A recommendation was made.

The registered provider should ensure that obsolete warfarin and insulin dosage directions are cancelled and archived. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.4 Is care effective?

The majority of medicines examined had been administered in accordance with the prescriber's instructions. Some apparent discrepancies in the administration of insulin and inhaled medicines were observed. It was acknowledged that two supplies of these medicines had been in use. 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 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. Care plans were in place. 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 in the daily care notes on some occasions only. The registered manager advised that this would be recorded on the daily count sheet form the day of the inspection onwards.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place. 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 assessment tool was used as needed. 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. Care plans and speech and language assessment reports were in place. Registered nurses recorded administration on the medication administration records. Care assistants were also responsible for administering thickening agents but records were not maintained. A requirement was made.

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. However, as stated in Section 4.3 two registered nurses should sign hand-written updates on the medication administration records.

Practices for the management of medicines were audited throughout the month by the staff and management.

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

Areas for improvement

The registered provider must ensure that complete records for the administration of thickening agents are maintained. A requirement was made.

Number of requirements	1	Number of recommendations	0

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.

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 25 questionnaires were issued to patients, relatives/patients' representatives and staff, with a request that they were returned within one week from the date of the inspection. Three patients and four members of staff completed and returned the questionnaires. The responses were positive and these were recorded as "satisfied" or "very satisfied" with regard to the management of medicines in the home.

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 confirmed that written policies and procedures for the management of medicines were in place and that they were reviewed regularly. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

The registered manager advised that there were robust arrangements in place for the management of medicine related incidents. The registered manager confirmed that staff 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.

The recommendations made at the last medicines management inspection had been addressed.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff either individually or via team 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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Barbara Foster, 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 pharmacists@rqia.org.uk 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

Statutory Requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 14 January 2017	The registered provider must ensure that complete records for the administration of thickening agents are maintained.
	Response by registered provider detailing the actions taken: Carers responsible for using thickening agents are now signing in a seperate book that they have administered the thickening agent to the appropriate resident.
Recommendations	
Recommendation 1 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 14 January 2017	The registered provider should ensure that hand-written updates/entries on the medication administration records (MARs) are verified and signed by two registered nurses.
	Response by registered provider detailing the actions taken: Staff Nurses made aware of the importance of double signatures on any handwritten entries / updates, this was re-emphasised at staff meeting last week.
Recommendation 2 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 14 January 2017	The registered provider should ensure that obsolete warfarin and insulin dosage directions are cancelled and archived.
	Response by registered provider detailing the actions taken: Obsolete Warfarin and Insulin dose directions are now cancelled and archived. Again this was re-emphasised at last week's staff meeting.

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

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