Unannounced Medicines Management Inspection Report
12 June 2017

Melmount Manor Care Centre

Type of Service: Nursing Home
Address: 1 Orchard Road, Strabane, BT82 9QR
Tel no: 028 7138 3990
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 81 beds that provides care for patients requiring nursing care living with dementia or a physical disability and patients requiring residential care with dementia.

3.0 Service details

Organisation/Registered Provider: Larchwood Care Homes (NI) Ltd/ **Responsible Individual:** Mr Christopher Walsh	**Registered manager:** Mrs Annie Frobisher
Person in charge of the home at the time of inspection: Mrs Annie Frobisher	**Date manager registered:** 28 December 2012
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. Residential Care (RC) DE – Dementia.	**Number of registered places:** 81 A maximum of 38 patients in category NH-DE, 31 patients in categories NH-I and NH-PH and a maximum of 12 residents in category RC-DE

4.0 Inspection summary

An unannounced inspection took place on 12 June 2017 from 09.25 to 13.55.

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 Melmount Manor 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.

No areas requiring improvement were identified.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Annie Frobisher, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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 required to be taken following the most recent inspection on 10 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

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection we met with the registered manager, four registered nurses and two care assistants.

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 10 May 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be reviewed by the care inspector once it is returned to RQIA. 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 7 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 manager must review and revise the management of medicines prescribed for external use.	**Met**
	Action taken as confirmed during the inspection: A new procedure was in place where the care staff sign the topical medicines administration record sheets when they have administered the medication and it is then signed off by the registered nurses.	
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 38 **Stated:** Second time	The registered manager should review and revise the management of records of the administration of thickening agents by care staff.	**Met**
	Action taken as confirmed during the inspection: These records had been reviewed and revised. They specified the level of thickener consistency.	

Area for improvement 2 **Ref:** Standard 38 **Stated:** Second time	The registered manager should ensure that all records of the administration of bisphosphonates clearly indicate that they have been administered clear of food and other medicines, in accordance with the manufacturers' instructions.	**Met**
	Action taken as confirmed during the inspection: The medicine administration record had been revised to include an administration time of 07:30 and clear directions were included on the record as to how bisphosphonates should be administered.	
Area for improvement 1 **Ref:** Standard 28 **Stated:** First time	The registered manager should ensure that the systems for auditing and monitoring medicines are robust.	**Met**
	Action taken as confirmed during the inspection: The monthly medication audit had been expanded to include those areas of practice where improvements were required to be made.	

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 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. 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 satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medicine administration records were updated by two designated staff members. This safe practice was acknowledged.

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

There were procedures in place to ensure the safe management of medicines during a patient's admission or readmission to the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. 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, 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 of good practice

There were examples of good practice in relation to staff training, competency assessments, the management of medicines on admission 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, 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.

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. A pain assessment tool was used as needed and 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 well maintained and facilitated the audit process.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for solid dosage medicines not dispensed in the monitored dosage system blister packs, nutritional supplements and several inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist. 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 record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	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.

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.

It was not possible to ascertain the views and opinions of patients during the inspection. 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 residents, patients' representatives and staff. No questionnaires were returned within the specified timeframe.

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 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. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following 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 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 of good practice

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

Areas for improvement

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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.

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