Unannounced Medicines Management Inspection Report
23 May 2017

Ard Mhacha House Care Centre

Type of Service: Nursing Home
Address: Desart Lane South, Armagh, BT61 8AR
Tel No: 028 3752 6462
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Ard Mhacha House Care Centre took place on 23 May 2017 from 09:40 to 14:40. The Cathedral, Navan and Orchard Suites were inspected.

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. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. It was evident that the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. There were no areas for improvement identified.

Is care effective?

The management of medicines generally supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. One area for improvement was identified in relation to record keeping and 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. Patients consulted with confirmed that they were administered their medicines appropriately. There were no areas for 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 for 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 Ard Mhacha House Care Centre which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	0

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Norma McAllister, 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 3 May 2017.

2.0 Service details

Registered organisation/registered provider: Runwood Homes Ltd / Mr John Rafferty	**Registered manager:** Mrs Norma McAllister
Person in charge of the home at the time of inspection: Ms Leanne McGaffin (Deputy Manager)	**Date manager registered:** 23 October 2015
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E), RC-DE	**Number of registered places:** 74

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 reported to RQIA since the last medicines management inspection.

We met with three patients, the registered manager, the deputy manager, three registered nurses, one care assistant and one patient's representative.

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. One relative availed of this opportunity during the inspection.

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

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
- care plans
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 3 May 2017

The most recent inspection of the home was an unannounced care inspection. The inspection report was issued on 26 May 2017 and the completed QIP will be reviewed 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 20 June 2016

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 29 **Stated:** First time	The registered provider should ensure that robust arrangements are in place for the management of records for patients prescribed thickening agents; records should be fully maintained.	**Met**
	Action taken as confirmed during the inspection: For those patients prescribed a thickening agent, this was recorded on their personal medication record and medicine administration record. Administrations were recorded. Care plans and speech and language assessment reports were in place. Details of the fluid consistency were not always recorded on the personal medication record and medicine administration record; however, the registered manager provided RQIA with confirmation, by email, that this matter had been rectified.	

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. 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 generally in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage.

Procedures were generally in place to ensure the safe management of medicines during a patient's admission to the home. Personal medication records and medicine administration records were signed by two staff members. These records correlated with the medication profiles received on admission. However, two recently admitted patients each had one medicine unavailable; the registered nurses stated they were awaiting delivery of the medicines that day. This was discussed with the registered manager, who gave an assurance that there would be an increased level of monitoring of the stock control of medicines belonging to newly admitted patients.

The management of antibiotics and new medicines was examined. The advice of the general medical practitioner had been recorded in the patient's notes and the medicines had been obtained without delay. The medicines had been administered appropriately. However, in Navan Suite, none of the four antibiotics and new medicines examined had been recorded on the personal medication record (see section 4.4 for area of improvement identified).

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.

Appropriate arrangements were in place for administering medicines in disguised form.

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 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, 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 generally recorded. A care plan was usually maintained; however, one patient did not have a care plan. The registered manager gave an assurance that this would be rectified without delay.

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 assessment 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.

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 generally satisfactory manner and facilitated the audit process. However, as specified in section 4.3, several personal medication record sheets in Navan Suite had not been accurately maintained; a requirement was made. Some personal medication record sheets were untidy and needed to be rewritten; the registered manager gave an assurance that this matter would be promptly dealt with.

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 and for some inhaled medicines. The dates and times of opening of the medicine containers were recorded in order to facilitate audit activity; this was acknowledged as good practice. Staff in each unit completed a medication audit each week and reported the outcomes to management. Management conducted a monthly audit. 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,

Areas for improvement

Personal medication records must be accurately 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 spoken with advised that they were very satisfied with the care experienced. 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. One patient's representative expressed satisfaction with the care provided to their relative.

As part of the inspection process, we issued questionnaires to patients, patients' representatives and staff. No questionnaires were returned from patients or patients' representatives within the specified timeframe. Two members of staff completed a questionnaire. The responses were positive and raised no concerns about 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?

Written policies and procedures for the management of medicines were in place. Management advised that these were reviewed on a regular basis. 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. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents.

Staff knew the identity of their adult safeguarding lead. They knew that medicine incidents should be considered under safeguarding procedures and how to report these.

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. The need for the level of monitoring of the stock control of medicines for newly admitted patients and the maintenance of the personal medication record sheets in Navan Suite to be increased was discussed with the registered manager and an assurance was given that this would happen.

Following discussion with the deputy 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. They advised that any resultant action was communicated with them.

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 Norma McAllister, 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 Web Portal 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:** 22 June 2017	The registered provider must ensure that personal medication record sheets are accurately maintained.
	Response by registered provider detailing the actions taken: All medication records have been reviewed and amended as required to ensure that they accurately maintained. A new correlation system has been implemented to ensure that the Kardex and MARS record is quality assured. All staff involved in the administration of medicines have been provided with a copy of this report and Quality Improvement Plan.

The Regulation and Quality Improvement Authority

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