

Unannounced Medicines Management Inspection Report 19 December 2016



Woodlawn House

Type of Service: Nursing Home
Address: Quarry Lane, Dungannon, BT70 1HX
Tel no: 028 8771 3565
Inspector: Cathy Wilkinson

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Woodlawn House took place on 19 December 2016 from 10.40 to 12.30.

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 working relationship with the patients' carers, 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 of improvement identified.

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. There were no areas of improvement identified.

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 share 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.

1.1 Inspection outcome

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Ms Maureen Currie, 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.

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 17 August 2016.

2.0 Service details

Registered organisation/registered person: Southern HSC Trust Mr Francis Rice	Registered manager: Ms Maureen Edna Currie
Person in charge of the home at the time of inspection: Mrs Maureen Currie	Date manager registered: 8 August 2008
Categories of care: NH-LD, NH-LD(E)	Number of registered places: 8

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 two patients, one registered nurse, two care staff, and the registered manager.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA within one week.

A sample of the following records was examined:

- 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 17 August 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 13 April 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 Ref: Standard 28 Stated: First time	It is recommended that the care plan details the circumstances under which any medicine, prescribed for administration on a “when required” basis in the management of distressed reactions, is to be administered.	Met
	Action taken as confirmed during the inspection: The registered manager advised that none of the patients required medicine on a “when required” basis for the management of distressed reactions. A care plan detailing the management of distressed reactions was observed for one patient. The registered manager advised that these care plans are in place even if medicines are not prescribed to manage the distressed reactions.	

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 e.g. thickened fluids. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in epilepsy management and buccal midazolam was provided in the last year.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses. This safe practice was acknowledged. The registered manager advised that the registered nurses in the home had access to the NIECR which allows them to view the medicines which are currently prescribed by the patients' GP.

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.

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
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4.4 Is care effective?

The sample of medicines examined had mostly been administered in accordance with the prescriber's instructions. A small number of discrepancies were noted and shared with the registered manager who agreed to closely monitor medicines during the patient's stay. There was evidence that time critical medicines had been administered at the correct time.

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 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.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record. Each administration was recorded and care plans 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.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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4.5 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.

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

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.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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4.6 Is the service well led?

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.

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 for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.



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