Unannounced Medicines Management Inspection Report
11 November 2016

Ailsa Lodge

Type of service: Nursing Home
Address: 6 Killaire Avenue, Carnalea, Bangor, BT19 1EW
Tel no: 028 9145 2225
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of Ailsa Lodge took place on 11 November 2016 from 10.00 to 12.55.

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 community pharmacist, 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. No requirements or 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. 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 Mrs Ada Johnston, Nurse in Charge, 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 14 October 2016.

2.0 Service details

Registered organisation/registered person: Ailsa Lodge / Mrs Jacqueline Robinson	**Registered manager:** Mrs Jacqueline Robinson
Person in charge of the home at the time of inspection: Mrs Ada Johnston, Nurse in Charge	**Date manager registered:** 1 April 2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 41

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home

Prior to the inspection, it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with one registered nurse, one care member of care staff and the nurse in charge.

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 total of fifteen questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA within one week. Six questionnaires were returned on the day 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 14 October 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP from that inspection is due to be returned by 8 December 2016. 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 25 November 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 28 **Stated:** First time	Inhaled medicines should be regularly audited to ensure that they are being administered as prescribed.	**Met**
	Action taken as confirmed during the inspection: A running stock balance is recorded for inhaled medicines to monitor the administration.	
Recommendation 2 **Ref**: Standard 31 **Stated:** First time	Written Standard Operating Procedures for the management of controlled drugs which are specific to this home should be implemented.	**Met**
	Action taken as confirmed during the inspection: Written Standard Operating Procedures had been drafted and implemented in November 2015.	

Recommendation 3 **Ref**: Standard 18 **Stated:** First time	The management of medicines prescribed on a "when required" basis for the management of distressed reactions should be reviewed to ensure that all of the appropriate records are maintained.	**Met**
	Action taken as confirmed during the inspection: The management of these medicines were reviewed and all appropriate records had been completed.	

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. 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 August 2016. Regular lunchtime learning sessions are also organised for staff to attend.

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 satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses. This safe practice was acknowledged.

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

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. Staff were reminded that the checks should continue until the medicines are disposed of. Additional checks were also performed on other controlled drugs which is good practice.

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 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. 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 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. Areas of good practice were acknowledged.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for analgesics and inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the staff, it was evident that other healthcare professionals are contacted when required to meet the needs of the patients.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.5 Is care compassionate?

The administration of medicines was not observed during this inspection. However the registered nurses were knowledgeable about the patients' needs and preferences. Interactions between staff and patients were observed to be caring and timely.

At the time of the inspection patients were provided with the opportunity of attending a Remembrance Day service in the home.

Questionnaires were completed by three patients. All of the responses in the questionnaires indicated that patients were either “satisfied” or “very satisfied” with how medicines are managed in the home.

Three of the registered nurses completed questionnaires. All of the responses were positive and raised no concerns with how medicines were managed within 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. There was evidence 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.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents.

A review of the internal 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 nurse 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

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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