Unannounced Medicines Management Inspection Report
18 October 2016

Carnalea

Type of Service: Nursing Home
Address: 20-30 Crawfordsburn Road, Bangor, BT19 1BE
Tel no: 028 9145 1121
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Carnalea took place on 18 October 2016 from 10.20 to 15.05.

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 most areas for the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines were trained and competent. One area for improvement in relation to ensuring that patients have a continuous supply of their prescribed medicines was identified. A requirement was made.

Is care effective?

Most areas of the management of medicines supported the delivery of effective care. However two areas for improvement in relation to maintaining accurate records for the administration of medicines and retaining medicines in their original/ dispensed container until the point of administration were identified. Two requirements were 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. No requirements or recommendations were made.

Is the service well led?

The service was found to be well led with respect to some areas of 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. No requirements or recommendations were made.

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	3	0

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Josette Fernandez, 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 5 May 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Ms Josette Fernandez
Person in charge of the home at the time of inspection: Ms Josette Fernandez	**Date manager registered:** 8 February 2016
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 73

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 one patient, one care assistant, three registered nurses 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 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 5 May 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 dated 5 November 2016

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 18 **Stated:** First time	The management of medicines which are prescribed to be administered "when required" for the management of distressed reactions should be reviewed and revised as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The management of distressed reactions was discussed in detail. Care plans were in place and the reason for and outcome of administration were recorded on the reverse of the administration records and in the daily care notes.	

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.

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. However despite these systems two medicines had been out of stock (on the first floor) in the last two weeks; five doses of each medicine had been omitted. One of the medicines had been unavailable at the community pharmacy and registered nurses had not tried to obtain the medicine from another community pharmacy. The registered manager had not been made aware and it had not been reported to the prescriber. The registered provider must ensure that robust procedures are in place to ensure that medicines are available for administration as prescribed. A requirement was made.

Mostly satisfactory arrangements were in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged. However one personal medication record and one medication administration record had not been accurately updated on the ground floor; it was acknowledged that the correct medication had been administered. The registered nurse advised that this had been an oversight. The registered manager agreed to closely monitor the management of medication changes.

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.

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.

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.

The majority of medicines were stored safely and securely and in accordance with the manufacturer's instructions. 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. However, the consistent recordings for the maximum/minimum temperatures of the refrigerators indicated that the thermometers were not being reset each day. The registered manager advised that registered nurses would be given supervision on monitoring the refrigerator temperature and resetting the thermometer and that the recordings would be closely monitored to ensure satisfactory recordings/temperatures are achieved.

Areas for improvement

The registered provider must ensure that robust procedures are in place to ensure that medicines are available for administration as prescribed. A requirement was made.

Number of requirements	1	**Number of recommendations**	0

4.4 Is care effective?

The majority of medicines examined had been administered as prescribed. 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. However, on the ground floor the registered nurse had signed that laxative medicines had been administered to a number of patients during the morning round.

The medicines had been removed from their boxes and set aside for administration at a later time. This is unsatisfactory. Medicines must be retained in their original/dispensed container until the point of administration. Registered nurses must only sign the records of administration when the medicines have been administered. Two requirements were made.

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 on the reverse of the medication administration records and in the daily care notes.

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.

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 reports were in place. Administration was being recorded on the medication administration records and in the daily diet booklets.

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. The registered nurse on the ground floor advised that one refusal was being referred to the prescriber on the day of the inspection.

With the exception of the records discussed in Section 4.3 and the administration records for laxative medicines (detailed above) medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included transdermal patch application records, antibiotic charts and injection charts. Registered nurses were reminded that obsolete personal medication records should be cancelled and archived.

Practices for the management of medicines were audited throughout the month by both staff and management. These included daily, weekly and monthly audits. 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 medication related issues.

Areas for improvement

The registered provider must ensure that registered nurses do not sign the records of administration of medicines prior to their administration. A requirement was made.

The registered provider must ensure that medicines are retained in their original/dispensed container until the point of administration. A requirement was made.

Number of requirements	2	Number of recommendations	0

4.5 Is care compassionate?

The registered manager advised that arrangements were in place to facilitate patients to manage their own medicines when possible.

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.

We spoke with one patient who advised that they had no complaints and that staff were very good. They confirmed that pain relief would be administered without delay if requested.

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. 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 home's 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. They advised that any resultant action was communicated with staff either individually or at 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 Ms Josette Fernandez, 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 the **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:** 17 November 2016	The registered provider must ensure that robust procedures are in place to ensure that medicines are available for administration as prescribed.
	Response by registered provider detailing the actions taken: System on ordering of medicines and management of unavailable medicines reviewed with the Staff. Reporting medication issues has been reinforced with the staff to ensure actions are taken immediately.
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 17 November 2016	The registered provider must ensure that registered nurses do not sign the records of administration of medicines prior to their administration.
	Response by registered provider detailing the actions taken: Registered Nurses were asked to review FSHC Medication Management policy and NMC medicine management policy. Management of medicine supervision and competencies completed. Regular monitoring by Unit Sisters and Home Manager in place.
Requirement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 17 November 2016	The registered provider must ensure that medicines are retained in their original/dispensed container until the point of administration.
	Response by registered provider detailing the actions taken: Medication supervision and competencies completed. System of administration of laxatives reviewed.

Please ensure this document is completed in full and returned via web portal

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