Unannounced Medicines Management Inspection Report
20 October 2016

Carryduff Nursing Home

Type of Service: Nursing Home
Address: 19 Church Road, Carryduff, BT8 8DT
Tel no: 028 9081 4862
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Carryduff Nursing Home took place on 20 October 2016 from 10.00 to 14.30.

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 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. 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. However two areas for improvement in relation to accurate administration records and distressed reactions were identified. One requirement and one recommendation 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. 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 cascade 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	1	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Jinu Mathew, Acting Manager, and Mrs Linda Kelly, Regional Support Manager, as part of the inspection process. The timescales for completion commence from the date of 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 July 2016.

2.0 Service details

Registered organisation/registered person: Mr Edwin Samuel Johnston Mr Gerald William Beattie	**Registered manager:** Mrs Jinu Mathew
Person in charge of the home at the time of inspection: Mrs Jinu Mathew (Acting Manager)	**Date manager registered:** Acting - No application required
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 23

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 care assistant, the acting manager and the regional support manager.

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 July 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 8 October 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must investigate the apparent discrepancy in the administration of Lyrica 200mg capsules for Patient A. The prescriber must be informed if necessary. The outcome of the investigation including the action taken to prevent a recurrence must be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: The investigation was completed and proved inconclusive. The registered manager closely monitored the administration of this medicine following the last medicines management inspection.	
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that a detailed epilepsy management plan is in place for patients who are prescribed rectal diazepam.	**Met**
	Action taken as confirmed during the inspection: Detailed epilepsy management plans were in place for those patients who were prescribed rectal diazepam.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 37 **Stated:** First time	Quality control checks should be performed on each blood glucose meter in accordance with the manufacturers' instructions.	**Met**
	Action taken as confirmed during the inspection: Two blood glucose meters were in use. Quality control checks were being carried out at weekly intervals.	
Recommendation 2 **Ref:** Standard 38 **Stated:** First time	Whenever an insulin supplementary recording sheet is in use, the insulin should be documented in the main personal medication record sheet and cross-referenced to the supplementary recording sheet.	**Met**
	Action taken as confirmed during the inspection: The brand of insulin and dosage directions were recorded on the personal medication records and supplementary insulin recording sheets.	
Recommendation 3 **Ref:** Standard 37 **Stated:** First time	The registered manager should closely monitor the administration of Seretide Evohalers as part of the home's audit activity.	**Met**
	Action taken as confirmed during the inspection: Seretide Evohalers were not in use. The acting manager advised that running stock balances are maintained when they are prescribed.	
Recommendation 4 **Ref:** Standard 38 **Stated:** First time	Two nurses should verify and sign all updates on the personal medication records.	**Met**
	Action taken as confirmed during the inspection: Two registered nurses had signed the personal medication records at the time of writing and at each update.	

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. Plans were in place to complete competency assessments. Refresher training in medicines management had been provided by the community pharmacist in October 2016. Care staff had received training in the management of thickening agents in May 2016. Training on the management of distressed reactions had been provided for staff in September 2016.

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 and discharge from the home.

Records of the receipt and administration of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. A number of discontinued controlled drugs had recently been denatured and disposed of. The disposal had been recorded in the handover sheets but had not been recorded in the controlled drug record book. The regional support manager and acting manager advised that this was an oversight and agreed to update the controlled drug record book immediately following the inspection. 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, insulin and rectal diazepam. The use of separate administration charts was acknowledged. The acting manager was reminded that the date of opening should be recorded on insulin pens to facilitate audit and disposal at expiry. It was acknowledged that the pens would be finished prior to their expiry being reached due to the doses prescribed.

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 and 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 records. 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. Care plans were in place. The reason for and the outcome of administration were recorded on some but not all occasions. A recommendation was made.

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. 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. Care plans and speech and language assessment reports were in place. Administration was recorded.

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. They included separate records for the administration of transdermal patches and distressed reaction recording sheets. However, it was noted that the morning medicines were being signed at 8.30 am when some were being administered as late as 11.40 am. The acting manager advised that some patients liked to have a lie in and did not want to take their medicines until they were up and dressed. She confirmed that appropriate dosage intervals were being adhered to. The time of administration of medicines must be accurately recorded. A requirement was made.

Practices for the management of medicines were audited throughout the month by both staff and management. This included running stock balances for some medicines and end of box audits for the majority of medicines.

Following discussion with the acting manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas for improvement

The time of administration of medicines must be accurately recorded. A requirement was made.

The management of distressed reactions should be closely monitored to ensure that the reason for and outcome of each administration are recorded on all occasions. A recommendation was made.

Number of requirements	1	Number of recommendations	1

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. As stated in Section 4.4 patients were administered their morning medicines at a time of their choice.

The patients we spoke to advised that they were happy with the care provided 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

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. The regional support manager confirmed that they were reviewed and updated regularly.

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. The regional support manager advised that a new management audit was due to be implemented.

Following discussion with the acting manager 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 via 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 Jinu Mathew, Acting Manager, and Mrs Linda Kelly, Regional Support 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:** 21 November 2016	The registered provider must ensure that the time of administration of medicines is accurately recorded.
	Response by registered provider detailing the actions taken: Supervisions and a staff meeting have been carried out with the nurses and the time of of the administration of medicines is acurately recorded on the administration records
Recommendations	
Recommendation 1 **Ref:** Standard 8 **Stated:** First time **To be completed by:** 21 November 2016	The registered provider should ensure that the management of distressed reactions is closely monitored to ensure that the reason for and outcome of each administration are recorded on all occasions.
	Response by registered provider detailing the actions taken: A form has now been implemented to evidence the outcome of medication administered for distressed reactions and this will be monitored.

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

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