The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report
24 April 2017

Cedarhurst Lodge

Type of service: Nursing Home
Address: Cedarhurst Road, Belfast, BT8 4RH
Tel no: 028 9049 2722
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of Cedarhurst Lodge took place on 24 April 2017 from 10.10 to 13.30.

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 generally supported the delivery of safe care and positive outcomes for patients. Staff administering medicines were trained and competent. Two areas of improvement were identified, one in relation to the security of medicines and one in relation to record keeping. Two 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 for 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. Patients consulted with confirmed that they had no concerns regarding the management of their medicines. 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 share 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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Lavina Harris, 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

The previous inspection was to inspect a proposal to vary the registration of the home. This will be followed up by the care inspector.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Mrs Lavina Ann Harris
Person in charge of the home at the time of inspection: Mrs Lavina Ann Harris	**Date manager registered:** 13 June 2007
Categories of care: NH-DE, NH-MP, NH-MP(E)	**Number of registered places:** 43

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, the registered manager and three registered nurses.

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.

Fifteen questionnaires were left in the home for completion by patients, staff and patient's representatives.

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 12 April 2017

The most recent inspection of the home was an announced inspection for a variation to the registration of the home. This will be followed up by the care and estates inspectors.

4.2 Review of requirements and recommendations from the last medicines management inspection 4 April 2016

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 18 **Stated:** First time	The registered person should ensure that the management of medicines prescribed on a “when required” basis for the management of distressed reactions is reviewed and revised to ensure that all of the appropriate records are maintained.	**Met**
	Action taken as confirmed during the inspection: All of the 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 the last year. Palliative care training is planned for the coming months.

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 appropriate arrangements in place for the storage of prescriptions.

There were satisfactory arrangements in place to manage changes to prescribed medicines in the Beech Suite. The personal medication records in the Sycamore Suite should be closely monitored to ensure that they are up to date at all times. This was discussed with the registered manager. A recommendation was made.

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. 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. insulin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Medicines were generally stored safely and securely and in accordance with the manufacturer's instructions. It was noted however that the medicines keys were routinely left unattended in the lock of the trolley during medicine rounds. This was observed on a number of occasions during the medicine round even after it was brought to the attention of the registered nurse. The registered manager should ensure that medicines keys are not left unattended in this manner. A recommendation was made.

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. Staff in the home advised that they had been having some issues with the medicine refrigerators and had requested that they be replaced. This was confirmed by the registered manager.

There were safe systems in place for the storage of prescriptions.

Areas for improvement

The registered person should ensure that the medicine keys are not left unattended in the trolley during the medicine rounds. A recommendation was made.

The registered person should ensure that the personal medication records in the Sycamore Suite are closely monitored to ensure that they are accurate at all times. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.4 Is care effective?

The majority 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 some of the patients could verbalise pain, and a pain assessment tool was used as needed. A care plan was maintained. 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. Each administration was recorded and care plans and speech and language assessment reports were in place.

The management of antibiotics was examined. The advice of the general practitioner had been recorded in the patient’s notes and the antibiotic had been obtained without delay. The medicine had been administered appropriately. The antibiotic had not been recorded onto the patient’s personal medication record. This was brought to the attention of the registered manager who agreed that this would be updated without delay.

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 extra records for the administration of high risk medicines, the application of transdermal patches and medicines that are prescribed to be administered on a “when required” basis.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for medicines not contained within the monitored dosage system and weekly audits of creams and thickening agents. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that other healthcare professionals are contacted when required to meet the needs of 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?

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients were treated courteously, with dignity and respect. Good relationships were evident.

We spoke to two patients during the inspection. No concerns were raised regarding the management of medicines.

Five patients completed the questionnaires. All of the responses indicated that they were "very satisfied" with how medicines were managed.

Questionnaires were completed by four patients' relatives. All of the responses indicated that they were "very satisfied" with how medicines were managed.

Five members of staff completed the questionnaire and no concerns were raised.

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 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. 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.

The registered manager was nominated as the adult safeguarding lead. Staff knew that medicine incidents should be considered under safeguarding procedures and how to report these.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Lavina Harris, 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 via 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

Recommendations	
Recommendation 1 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 24 May 2017	The registered person should ensure that the medicine keys are not left unattended in the trolley during the medicine rounds.
	Response by registered provider detailing the actions taken: The Registered Manager spoke with Staff Nurse concerned to ensure that keys are not left in the medicine trolley during medicine rounds. The Registered Manager will monitor this to ensure that the keys are not left in the trolley during her daily walkabout around the Home.
Recommendation 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 24 May 2017	The registered person should ensure that the personal medication records in the Sycamore Suite are closely monitored to ensure are accurate at all times.
	Response by registered provider detailing the actions taken: The Registered Manager spoke with the trained staff concerned. The Registered and Deputy Managers continue to monitor this during daily walkabouts and drug audits to ensure that the personal medication records are accurate at all times.

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