Unannounced Medicines Management Inspection Report
10 November 2016

Clandeboye

Type of Service: Nursing Home
Address: 35 Cardy Close, Bangor, BT19 1AT
Tel no: 028 9127 1011
Inspector: Judith Taylor

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Clandeboye took place on 10 November 2016 from 10.15 to 15.20.

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. 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 that patients were receiving their medicines as prescribed. Care plans regarding specific areas of medicines management were maintained. One area of improvement was identified in relation to record keeping and a recommendation was 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 generally 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. However, as there were some areas for improvement identified, a review of the audit process should be undertaken. One recommendation was 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	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Joanne Roy, 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 October 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/ Dr Maureen Claire Royston	**Registered manager:** Mrs Joanne Roy
Person in charge of the home at the time of inspection: Mrs Joanne Roy	**Date manager registered:** 9 December 2010
Categories of care: NH-DE	**Number of registered places:** 52

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the incidents register – it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

We met with one patient, one member of care staff, 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.

Twenty questionnaires were issued to relatives/patients' representatives and staff, with a request that they were returned within one week from the date 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 5 October 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved. The 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 3 June 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 29 **Stated:** First time	It is recommended that the registered person should review the management of medicines prescribed on a "when required" basis for distressed reactions, to ensure that the reason for and outcome of the administration is recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: There was evidence that a record of the reason for and outcome of the administration of these medicines had been maintained.	

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. Refresher training in medicines management including the administration of subcutaneous medicines was provided in the last year.

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 and handwritten entries on medication administration 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, 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.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. Staff were reminded that the disposal record should clearly indicate that controlled drugs had been denatured.

Most of the medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean and tidy. There was limited space in the overstock cupboards to enable adequate segregation of patients' medicines. The registered manager was aware of this and advised this was planned to be addressed by the organisation.

Whilst the date of opening was recorded on medicines with a limited shelf life once opened, two medicines had passed the in use expiry date and were removed from stock. These were replaced during the inspection. This was further discussed and it was agreed that this would be raised with staff and reviewed in the audit process. A recommendation regarding the audit process was made in Section 4.6. 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 also advised that a pain assessment was 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.

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.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the use of separate administration records for some medicines. However, some areas for improvement were identified in the standard of record keeping regarding personal medication records and medication administration records, in particular, external preparations. A recommendation was made.

Practices for the management of medicines were audited throughout the month by the staff and management. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to medicine management.

Areas for improvement

The completion of personal medication records and medication administration records should be closely monitored to ensure these are fully and accurately maintained. A recommendation was made.

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

4.5 Is care compassionate?

The administration of medicines to patients was completed in a caring manner. The patient was given time to take their medicines.

It was not possible to ascertain the views and opinions of patients.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. There was evidence of good relationships with staff.

As part of the inspection process, we issued questionnaires to staff and relatives/patients' representatives. Ten staff and two relatives/patients' representatives completed and returned questionnaires within the specified timeframe. The responses were recorded as 'very satisfied' or 'satisfied' with the management of medicines in 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. 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 and advised of the systems in place to ensure that all staff were made aware of incidents and how the learning was implemented.

A review of the internal audit records indicated that satisfactory outcomes had been achieved. The registered manager advised that an action plan was developed when areas for improvement were identified in the auditing process and further advised of the electronic communication systems which enabled staff to be made aware of these action plans. However, due to the inspection findings it was recommended that the audit process should be further developed.

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 and the outcomes were shared with them.

Areas for improvement

The audit process for medicines management should be further developed to ensure this covers the areas identified for improvement within the report. A recommendation was made.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Joanne Roy, 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	
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 10 December 2016	The registered provider should ensure that medicine records are fully and accurately completed on all occasions.
	Response by registered provider detailing the actions taken: The Registered Person will carry out 'spot audits' every two weeks of the MARs Record to ensure the documentation is correct and corresponds with care plans & prescriptions. All nurses will receive a supervision regarding the outcome of the inspection.
Recommendation 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 10 December 2016	The registered provider should further develop the audit process to ensure this covers all aspects of medicines management.
	Response by registered provider detailing the actions taken: The Registered Person will review the audit process for the home and include the improvements discussed during the inspection i.e. liquid audit, expiry dates.

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

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