Unannounced Medicines Management Inspection Report
21 February 2019

Clandeboye

Type of Service: Nursing Home
Address: 35 Cardy Close, Bangor, BT19 1AT
Tel No: 028 9127 1011
Inspector: Helen Daly

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home which provides care for up to 52 patients who are living with dementia.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** Ms Annie Joy Kamlian
Person in charge at the time of inspection: Ms Annie Joy Kamlian	**Date manager registered:** 4 June 2018
Categories of care: Nursing Homes (NH): DE – dementia	**Number of registered places:** 52 The home is approved to provide care on a day basis to one person.

4.0 Inspection summary

An unannounced inspection took place on 21 February 2019 from 10.35 to 14.30.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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.

The inspection assessed progress with any areas for improvement identified during and since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to medicines administration, medicine records, medicine storage and the management of controlled drugs.

No areas for improvement were identified at this inspection.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Annie Joy Kamlian, Registered Manager, 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.

4.2 Action/enforcement taken following the most recent care inspection

No further actions were required to be taken following the most recent unannounced care inspection undertaken on 28 November 2018. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the home was reviewed. This included the following:

- recent inspection reports
- recent correspondence with the home
- the management of medicine related incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

During the inspection we met with one patient, two care assistants, three registered nurses and the registered manager.

We provided the registered manager with 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. We left 'Have we missed you?' cards in the home to inform patients/their representatives, how to contact RQIA to tell us of their experience of the quality of care provided. Flyers providing details of how to raise concerns were also left in the home.

We asked the registered manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

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
- care plans
- training records
- medicines storage temperatures

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 28 November 2018

The most recent inspection of the home was an unannounced care inspection. There were no areas for improvement identified as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 28 November 2017

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 28

Stated: First time</td><td>The registered person shall review the management of warfarin to ensure robust arrangements are in place.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The management of warfarin had been reviewed and revised. Dosage directions were received in writing. Two registered nurses were involved in all transcriptions. Daily stock balances were maintained.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 18

Stated: First time</td><td>The registered person shall review the management of distressed reactions to ensure staff record details of the reason for and outcome of the administration of medicines on each occasion.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The reason for and outcome of administration were being recorded on the reverse of the medication administration records and/or in the daily progress notes.</td></tr>
</table>

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Medicines were managed by registered nurses who have been trained and deemed competent to do so. Training and competency assessments were updated annually. Records were available for inspection. Care assistants had received training and been deemed competent to administer thickening agents and emollient preparations. Training on the management of thickening agents had been provided on 13 February 2019.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training was provided annually.

There were largely satisfactory procedures in place to ensure the safe management of medicines during a patient's admission to the home and to manage medication changes. Personal medication records and hand-written entries on the medication administration records were verified and signed by two registered nurses. This safe practice was acknowledged. However, it was noted that the medication regime had not been confirmed with the general practitioner when patients were admitted from another care home. This was discussed with the registered manager who advised that this would commence from the date of the inspection onwards.

There were systems in place to ensure that patients had a continuous supply of their prescribed medicines. There was evidence that antibiotics and newly prescribed medicines had been received into the home without delay.

Robust arrangements were observed for the management of high risk medicines e.g. insulin and warfarin. See also Section 6.2. The use of separate administration charts was acknowledged.

Appropriate arrangements were in place for administering medicines in disguised form.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. The date of disposal of controlled drugs was not being recorded in one controlled drug record book. The registered manager was reminded that the date of disposal of controlled drugs should be recorded on all occasions. Stock balance checks were performed on controlled drugs which require safe custody, at the end of each shift.

There were arrangements in place for the safe disposal of discontinued or expired medicines.

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. Satisfactory recordings were observed for the daily room and refrigerator temperatures.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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 twice weekly, 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 record. Detailed care plans were in place and the reason for and outcome of administration were recorded. See Section 6.2. 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 sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Detailed care plans were in place. Pain assessment tools were used. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, care plans and speech and language assessment reports were in place.

Records of prescribing and administration, which included the recommended fluid consistency levels, were appropriately maintained.

Registered nurses advised 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. This was evidenced during the inspection.

The majority of medicines records were well maintained. However, it was noted that the date of writing had not been recorded on all personal medication records and that obsolete personal medication records had not been cancelled and archived. Assurances were provided that this would be addressed from the date of the inspection onwards.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for all medicines, a weekly audit on randomly selected medicines, thickening agents and emollient preparations. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and registered nurses, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in patient care.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We did not observe the administration of medicines during the inspection. Discussion with the registered nurses indicated that they were familiar with each patient's medication regimes and how/where they liked to take their medicines.

Throughout the inspection, it was found that there were good relationships between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity.

We observed several patients to be relaxed and comfortable in the lounge and during their lunch. There was a calm atmosphere in the home.

We spoke with one patient who was sitting in the nurses' station. The patient was chatting with staff and enjoying their company.

As part of the inspection process, we issued 10 questionnaires to patients and their representatives. One relative responded indicating that they were "satisfied" with the care provided.

Any comments from patients and their representatives in questionnaires received after the return date (two weeks) will be shared with the registered manager for information and action as required.

Areas of good practice

Staff were observed to listen to patients, engage them in conversation and respond promptly to any requests.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

We discussed arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. Arrangements were in place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. They were not reviewed at the inspection.

The registered manager advised that staff knew how to identify and report incidents and that they were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were examined. Management advised of the auditing processes completed by both staff and management. Areas identified for improvement were detailed in an action plan which was shared with staff to address and there were systems in place to monitor improvement.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They spoke positively about their work and advised there were good working relationships in the home with staff and the registered manager. They stated they felt well supported in their work and advised that any concerns in relation to medicines management were raised with the registered manager.

No online questionnaires were completed by staff within the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to governance arrangements and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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