Unannounced Medicines Management Inspection Report
28 November 2017

Clandeboye

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

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 with 52 beds that provides care for patients with a living with dementia.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** Mrs Joanne Roy
Person in charge at the time of inspection: Mrs Joanne Roy	**Date manager registered:** 9 December 2010
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 28 November 2017 from 10.10 to 16.15.

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, the standard of record keeping, care planning regarding medicines, staff training and the management of controlled drugs.

Areas requiring improvement were identified in relation to the management of warfarin and distressed reactions.

We met with one patient who spoke positively about the care provided by staff and the management of their medicines.

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	2

Details of the Quality Improvement Plan (QIP) 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.

4.2 Action/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 3 October 2017. At this inspection, RQIA was concerned that some aspects of the quality of care and service delivery within Clandeboye were below the minimum standard. The responsible individual was invited to a serious concerns meeting on 10 October 2017 to discuss the inspection findings and their action plan to address the issues identified. A full account was provided and RQIA were satisfied with these assurances.

5.0 How we inspect

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

- 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

A poster informing visitors to the home that an inspection was being conducted was displayed.

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

A total of 10 questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completion of 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
- policies and procedures
- 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 person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 3 October 2017

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 the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 10 November 2016

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time	The registered provider should ensure that medicine records are fully and accurately completed on all occasions.	**Met**
	Action taken as confirmed during the inspection: The sample of medicine records examined indicated that these were generally well maintained and systems were in place to review these as part of the internal auditing processes.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered provider should further develop the audit process to ensure this covers all aspects of medicine management.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the auditing process has been reviewed. The registered manager advised of the additional audits which had been implemented since the previous medicines management inspection and of the staff roles and responsibilities to oversee delegated tasks.	

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 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 and dementia was provided in the last year. Training in the management of dysphagia is planned next month.

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 and also advised of the difficulty on occasion in obtaining medicines within a timely manner. This was discussed and advice given. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and to manage changes to prescribed medicines.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed in March 2017.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Staff were reminded that the stock balance should be brought to zero when the complete stock of the controlled drugs has been disposed of or transferred. 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.

The management of high risk medicines was examined e.g. warfarin and insulin. Care plans were maintained. In relation to warfarin, an area for improvement was identified. The transcribing of warfarin dosage regimes should involve two staff with both staff signatures recorded; old regimes should be removed from the kardex folder and archived; and a daily stock balance should be maintained. Satisfactory arrangements were in place for the management of insulin. The benefit of using a separate chart to record insulin administration was discussed.

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. Two treatment rooms were in use. One of the treatment rooms was tidy and well organised; however, there was limited space in the other treatment room. The registered manager and staff advised that there had been ongoing discussions within the organisation to address this issue and confirmed that planned refurbishment work was to be commenced in the near future.

There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened e.g. eye preparations, insulin. Medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessment, the management of medicines on admission, the storage of prescriptions and medicines.

Areas for improvement

The management of warfarin should be reviewed.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

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

With the exception of one medicine, the sample of medicines examined had been administered in accordance with the prescriber's instructions. It was agreed that the administration of this medicine would be closely monitored from the day of the inspection onwards and that the prescriber would be contacted.

There were satisfactory arrangements in place to alert staff of when time critical medicines must be administered, such as medicines prescribed for Parkinson's, early morning medicines and also medicines which were prescribed at weekly or three monthly intervals.

When an antibiotic was prescribed a care plan was maintained. This is good practice.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions a care plan was maintained. The dosage instructions were recorded on the patient's 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 not routinely recorded. An area for improvement was identified.

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.

Overall, the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the separate administration records for transdermal patches; protocols for "when required" medicines and double signatures for the writing and updating of personal medication records and medication administration records. It was noted that a few personal medication record entries had been amended. Staff were reminded that a new medicine entry must be written; we were informed that this was the expected practice.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several medicines and a record of the stock balance of medicines carried forward to the next medicine cycle. This is good practice. A quarterly audit was also 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 the patients' healthcare needs.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the administration of medicines, the standard of record keeping and care planning. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

Details of the reason and outcome of the administration of medicines to manage distressed reactions should be recorded on each occasion.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

The administration of medicines to patients was completed in a caring manner. The patients were encouraged to take their medicines and given the necessary time to swallow their medicines. The medicines were administered as discreetly as possible.

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. It was clear from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes.

We were able to obtain the views and opinions of one patient. This patient spoke positively about the care provided by the staff, the food and the management of medicines. No concerns were raised.

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.

Whilst we had left questionnaires in the home to facilitate feedback from patients and their representatives, and also invited staff to share their views by completion of an online questionnaire, only one relative questionnaire was returned to RQIA at the time of issuing this report. The responses indicated that the relative was satisfied with the care provided in the home. No comments were made.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing patients and taking account of the views of patients.

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.

Written policies and procedures for the management of medicines were in place. These were not examined in detail. Staff advised that they were familiar with them and were kept up to date of any changes.

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 how incidents were shared with them to inform learning and change of practice, if necessary. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

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.

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 management were open and approachable and willing to listen. They also stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of medicine incidents, quality improvement and maintaining good working relationships.

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

Areas for improvement 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 if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 29 December 2017	The registered person shall review the management of warfarin to ensure robust arrangements are in place. Ref: 6.4
	Response by registered person detailing the actions taken: The Registered Manager met with all nurses to discuss the management of Warfarin and introduced a record to enable a daily count of each dose administered. The registered Manager will monitor this monthly through the Monthly Medication Audit.
Area for improvement 2 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 29 December 2017	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. Ref: 6.5
	Response by registered person detailing the actions taken: The Registered Manager has discussed through the supervision process with the nurses the need to document the reason for administrating a medication for distressed reactions on the back of the MARS and the outcome. This will be monitored by the Registered Manager through the auditing process.

Please ensure this document is completed in full and returned via Web Portal

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