Unannounced Medicines Management Inspection Report
23 February 2017

Clifton Nursing Home

Type of Service: Nursing Home
Address: 2a Hopewell Avenue, Carlisle Circus, Belfast, BT13 1DR
Tel no: 028 9032 4286
Inspector: Rachel Lloyd and Frances Gault

1.0 Summary

An unannounced inspection of Clifton Nursing Home took place on 23 February 2017 from 10:10 to 14:10.

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. There were systems in place to ensure the management of medicines was largely in compliance with legislative requirements and standards. Areas for improvement were identified in relation to the storage of medicines which require refrigeration, handwritten entries on medicine administration records and the disposal of medicines. One requirement and 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. Two areas for improvement were identified in relation to the management of medicines administered "'when required" for distressed reactions and recording the date of opening on medicines to facilitate audit. Two recommendations 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 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 cascade 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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Cathy McCorry, Acting 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 14 December 2016.

2.0 Service details

Registered organisation/registered person: Runwood Homes Ltd Mr John Rafferty	**Registered manager:** See below
Person in charge of the home at the time of inspection: Ms Cathy McCorry	**Date manager registered:** Ms Cathy McCorry Acting – No application required
Categories of care: NH-PH, NH-DE, NH-I	**Number of registered places:** 100

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 six patients, three care assistants, five registered nurses, the activity co-ordinator, the acting manager and briefly with the registered person.

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-five questionnaires were issued to patients, patients' relatives/representatives and staff, with a request that these were completed and returned to RQIA within one week 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 14 December 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.

One area to be addressed was in relation to the management of medicines. A requirement had been made that topical preparations must only be used for the named individual and not for communal use. Staff advised that this had been addressed and there was no evidence observed that these preparations were being administered other than to the patient for whom they were prescribed.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 19 May 2015

There were no requirements or recommendations made as a result of the last medicines management inspection.

4.3 Is care safe?

Medicines were managed by staff who had 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 appraisal. Competency assessments were completed annually. Training in the past year had included the management of the new monitored dosage system and the management of syringe drivers.

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. Some handwritten entries on medicine administration records had not been checked and signed by a second registered nurse. These records should be verified on every occasion. A recommendation was made.

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.

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

The disposal of discontinued and expired medicines was examined. Some controlled drugs in Schedule 4 (Part 1) had not been denatured and rendered irretrievable prior to disposal. Some medicines were being returned to the community pharmacy for disposal instead of the licensed waste contractor in accordance with the home's own policy. The disposal of medicines should be reviewed. A recommendation was made.

Medicines were mostly 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 most medicines with a limited shelf life, once opened. It was discussed and agreed that the date of opening should be recorded on all insulin pen devices.

Refrigerator temperature records in the Donegal and Toby Hurst units indicated that medicines were not being stored within the required temperature range (2-8°C) at all times and that the thermometer was not being reset after daily monitoring. The refrigerator in the Toby Hurst unit had no maximum-minimum thermometer; therefore only the current temperature was being recorded and not the temperature range as necessary. The management of medicines requiring refrigeration must be reviewed to ensure storage at the required temperature, that the temperature is monitored appropriately and that action is taken promptly if any there are deviations from the required range. A requirement was made.

Areas for improvement

Handwritten entries on medicine administration records should be verified on every occasion. A recommendation was made.

The disposal of medicines should be reviewed to ensure that Schedule 4 (Part 1) controlled drugs are denatured prior to disposal and that all medicines are disposed of via a licensed waste contractor. A recommendation was made.

The management of medicines requiring refrigeration must be reviewed as detailed in the report. A requirement was made.

Number of requirements	1	Number of recommendations	2

4.4 Is care effective?

The sample of medicines examined had mostly been administered in accordance with the prescriber's instructions. A small number of unexplained omissions and/or missing signatures were noted and discussed.

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. A care plan was maintained. The reason for and the outcome of administration were sometimes recorded. These should be recorded on every occasion. A recommendation was made.

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.

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

The registered nurses on duty 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 largely well maintained and facilitated the audit process. Areas of good practice were acknowledged. These included the use of transdermal patch application records and spot checks on balances of medicines not supplied in the monitored dosage system. However, it was not possible to complete audit trails on some medicines since the date of opening was not recorded. A recommendation was made.

Practices for the management of medicines were usually audited throughout the month by the staff and management. This included running stock balances for several medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered nurses on duty and a review of the care files, it was evident that when applicable, other healthcare professionals are contacted in response to concerns about medicines management.

Areas for improvement

The management of medicines administered "'when required" for distressed reactions should be reviewed to ensure that the reason for and the outcome of administration are recorded on every occasion. A recommendation was made.

The date of opening was should be recorded on all medicines to facilitate audit. A recommendation was made.

Number of requirements	0	Number of recommendations	2

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.

The patients spoken to were complimentary about their care in the home and about the staff. They spoke positively about the activities programme in the home. The 'singing barber' was in the home during the inspection. Several of the patients were looking forward to attending a tea dance in the local area that afternoon.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As part of the inspection process, questionnaires were issued to patients, relatives/patients' representatives and staff. No questionnaires were returned within the specified timescale.

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 improvement noted at the last inspection had been sustained as evidenced during this inspection and this was acknowledged.

Following discussion with the 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 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 Cathy McCorry, Acting 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 the 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:** 23 March 2017	The registered provider must ensure that the management of medicines requiring refrigeration is reviewed as detailed in the report.
	Response by registered provider detailing the actions taken: A new refrigerator is in place in the Donegal unit with a new fridge thermometer recording maximum- minimum fridge and room temerature.staff to check and record temperature daily on correct form. Toby unit new fridge thermometer recording maximum-minimum fridge and room temperature in place and staff to record daily.Deputy and home manager to monitor.
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 23 March 2017	The registered provider should ensure that handwritten entries on medicine administration records are verified on every occasion.
	Response by registered provider detailing the actions taken: Audit of medication Kardex carried out to ensure two nurse signatures are recorded on same. All staff nurses instructed to ensure this practice is reviewed weekly as part of the weekly medication audit. Deputies and Home manager to monitor same..
Recommendation 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 23 March 2017	The registered provider should ensure that the disposal of medicines is reviewed as detailed in the report.
	Response by registered provider detailing the actions taken: Disposal of discontinued and expired medicines was reviewed and staff instructed to follow home policy for same. Pharmacy contacted to ensure denatured kits are kept in stock in order to ensure controlled medications are disposed of correctly.staff instructed to dispose of medication weekly, two nurses to sign and record same.
Recommendation 3 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 23 March 2017	The registered provider should ensure that the management of medicines administered "'when required" for distressed reactions is reviewed to ensure that the reason for and the outcome of administration are recorded on every occasion.
	Response by registered provider detailing the actions taken: Staff nurses instructed to record in resident daily progress notes the reason for administration of prn medication for distress reactions, and the effect this had on the resident.ongoing monitoring of same by Deputy and home manager.

Recommendation 4 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 23 March 2017	The registered provider should ensure that the date of opening is recorded on all medicines to facilitate audit.
	Response by registered provider detailing the actions taken: A memo in the Medicine kardex file is in place stating that all boxed, bottled, creams and insulin pens are to have the opening date recorded on them to ensure correct audits of same and expiry date of short term medications. Deputy and Manager to monitor same.

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