Unannounced Medicines Management Inspection Report
6 June 2016

Corriewood Private Clinic

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Inspectors: Cathy Wilkinson and Frances Gault

1.0 Summary

An unannounced inspection of Corriewood Private Clinic took place on 6 June 2016 from 10.20 to 13.40.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern and a quality improvement plan (QIP) has not been included in this report.

Is care safe?

The management of medicines supported the delivery of safe care. 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 no areas of improvement identified.

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. Appropriate arrangements were in place for the management of pain and distressed reactions. There were no areas of 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. Patients consulted with confirmed that they were administered their medicines appropriately. There were no areas of 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 of 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. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

1.1 Inspection outcome

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs M.I. McGrady, (Registered Person) and Mrs Teresa McClean (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.

1.2 Actions/enforcement taken following the most recent medicines management inspection

The last RQIA inspection to the home was a medicines management inspection on 3 March 2016. Following this inspection we held a serious concerns meeting with the registered person and management of the home where we discussed the concerns that were raised during the inspection. The registered person provided a full account of the actions being taken to ensure that robust systems for the management of medicines were in place.

RQIA considered the matter and decided to allow a period of time to demonstrate improvement. This inspection took place to monitor the progress that had been made.

2.0 Service details

Registered organisation/registered person: Corriewood Private Clinic Mrs M I McGrady Mrs Anne Monica Byrne	**Registered manager:** Mrs Teresa Josephine McClean
Person in charge of the home at the time of inspection: Mrs Teresa Josephine McClean	**Date manager registered:** 1 April 2005
Categories of care: NH-LD, NH-LD(E), NH-I, NH-PH, NH-PH(E), NH-TI, NH-DE, NH-MP	**Number of registered places:** 63

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 four patients, one care assistant, two registered nurses, the registered manager and one of the registered persons.

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 inspectors. No one availed of this opportunity during 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 3 March 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector (see details of the validation during this inspection in section 4.2).

4.2 Review of requirements and recommendations from the last medicines management inspection dated 3 March 2016

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** Third time	The registered manager must implement a robust auditing system which monitors all aspects of the management of medicines.	**Met**
	Action taken as confirmed during the inspection: The auditing system has been reviewed to ensure that it is robust. Audits are completed daily by the registered nurses and the outcomes are reviewed by the registered manager. An action plan is produced and is placed in the communication folder for staff to reference and take action when necessary.	
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered person must ensure that patients have a continuous supply of medicines.	**Met**
	Action taken as confirmed during the inspection: Medicines were available for administration as prescribed.	
Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered person must ensure that the management of warfarin is reviewed and revised.	**Met**
	Action taken as confirmed during the inspection: The management of warfarin had been reviewed and revised. Written confirmation of the current warfarin regime was held on file and extra records for the administration were maintained. A running stock balance was recorded. The audits that were completed indicated that warfarin had been administered as prescribed.	
Requirement 4 **Ref:** Regulation 13(4) **Stated:** First time	The registered person must ensure that all personal medication records are fully and accurately maintained.	**Met**
	Action taken as confirmed during the inspection: The personal medication records that were examined had been fully and accurately maintained.	

Requirement 5 **Ref:** Regulation 13(4) **Stated:** First time	The registered person must ensure that the records relating to PEG tubes and fluid balance charts are fully completed.	**Met**
	Action taken as confirmed during the inspection: These records had been fully and accurately completed.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 28 **Stated:** Third time	The registered manager should ensure that the date of opening is recorded to facilitate audit.	**Met**
	Action taken as confirmed during the inspection: The date of opening had been recorded for those medicines examined during the inspection.	
Recommendation 2 **Ref**: Standard 29 **Stated:** First time	The registered person should ensure that all disposal records are fully maintained.	**Met**
	Action taken as confirmed during the inspection: The disposal records had been fully maintained.	
Recommendation 3 **Ref**: Standard 28 **Stated:** First time	The registered provider should ensure that further staff training in the management of medicines is provided for the registered nurses and competency assessments should be reviewed.	**Met**
	Action taken as confirmed during the inspection: Further training was provided on 23 March 2016 and 5 April 2016. A sample of training and competency records was provided for inspection.	
Recommendation 4 **Ref**: Standard 30 **Stated:** First time	The registered person should ensure that the storage arrangements for medicines are reviewed and revised.	**Met**
	Action taken as confirmed during the inspection: The storage arrangements had been reviewed and revised. All medicines were observed to be safely and securely stored.	

Recommendation 5 **Ref**: Standard 28 **Stated:** First time	The registered person should ensure that there are robust incident reporting systems in place and that all notifiable adverse incidents are appropriately reported to RQIA.	**Met**
	Action taken as confirmed during the inspection: The revised auditing system has aided the identification of notifiable incidents. Incidents have been appropriately managed and reported.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. Training had been provided for all registered nurses following the last medicines management inspection. Competency assessments were completed annually on a rolling basis.

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.

At the start of the inspection, a tray with labels was observed. This was discussed with the registered manager who advised that on occasion, more than one patients' medicines would be prepared prior to administration. The safety of this method was discussed and the registered manager was advised to seek further guidance on this matter.

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.

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. 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.

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 regularly. In the Springwell suite, the medicine storage area was observed to be 27^{o}C. This was discussed with the registered manager and it was agreed that the temperature would be closely monitored to ensure it stayed below the recommended temperature of 25^{o}C. Staff were reminded that the oxygen cylinder in this suite should be securely chained to the wall.

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 small sample of medicines examined had been administered in accordance with the prescriber's instructions. Further audits were not completed as the inspection took place on the first day of the medicine cycle and the majority of medicines had been opened that morning. There was evidence that time critical medicines had been administered at the correct time.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, specific 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 not in place for one of the two patients' records that were inspected. The registered nurse agreed that this would be completed following the inspection.

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 a pain tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment is completed as part of the admission process.

The management of swallowing difficulty was examined. For one patient, the thickening agent had not been recorded on the personal medication record and there was no record of the administration. The registered nurse confirmed that this patient's fluids were appropriately thickened by staff. It was agreed that the personal medication record for this patient would be rewritten and that a record of administration would be maintained. Records of the administration of thickening agent were observed for other patients.

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 recording running stock balances of analgesics and anxiolytics.

Practices for the management of medicines were audited throughout the month by the staff and management. A sample of audits was provided for inspection.

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

On arrival at the home we were greeted by staff and patients waiting on the arrival of the mobile petting zoo. Patients were very much looking forward to this experience and were observed to enjoy it through the course of the morning.

The administration of medicines to several patients was observed. Medicines were administered in the dining room with lunch or in the bedrooms. The registered nurses administering the medicines spoke to the patients in a kind manner.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were knowledgeable regarding their patients' needs, wishes and preferences. Staff and patient interaction and communication demonstrated that patients were treated courteously, with dignity and respect.

Medicines management was discussed with a small number of patients. All responses were positive regarding the administration of medicines.

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 and had been regularly reviewed. Following discussion with staff it was evident that they were familiar with the policies and procedures.

There were 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.

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.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

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