Unannounced Medicines Management Inspection Report
7 February 2017

Cairnmartin Court Care Home

Type of Service: Nursing Home
Address: 250 Ballygomartin Road, Belfast, BT13 3NG
Tel no: 028 9072 2050
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Cairnmartin Court Care Home took place on 7 February 2017 from 10.15 to 15.35.

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 most areas of the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines were trained and competent. There were largely satisfactory systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. However, two areas for improvement were identified in relation to the storage of medicines with respect to temperature and infection control; two requirements have been 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. Details regarding medicines management were recorded in the care plans. 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?

This service were found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place. There were robust systems to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. Some staff raised concerns in relation to the general management of the home and these concerns were shared with the regional manager for attention, and the care inspector. No requirements or recommendations were 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	2	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Patricia Amaral, Assistant Manager and Ms Karen McElherron, Regional Manager, Priory Elderly Care Ltd, 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 9 November 2016.

2.0 Service details

Registered organisation/registered person: Priory Elderly Care Ltd/ Mrs Caroline Denny	**Registered manager:** Ms Michelle Montgomery
Person in charge of the home at the time of inspection: Ms Patricia Amaral	**Date manager registered:** 10 June 2015
Categories of care: NH-PH, NH-DE, NH-I, NH-PH(E)	**Number of registered places:** 62

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 two patients, five care staff, two registered nurses and the assistant 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.

The following records were 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

As part of the inspection process, 26 questionnaires were issued to patients, relatives/ patient representatives and staff with a request that these were returned within one week of the inspection.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 9 November 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.

Following discussion with the care inspector, it was requested that the requirement made regarding health and safety and the use and positioning of extension leads would be examined. A review of the area of concern evidenced that this issue had been addressed.

4.2 Review of requirements and recommendations from the last medicines management inspection 10 November 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The arrangements for managing patients' medicines on admission must be reviewed.	**Met**
	Action taken as confirmed during the inspection: The procedures for managing medicines for new patients had been reviewed. Written confirmation of medicine regimes was received from the prescriber. Two registered nurses were involved in checking and transcribing medicine details on personal medication records and medication administration records.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must ensure that the incident where one BuTrans patch was not administered to a patient during October 2014 is investigated and a written response submitted to RQIA.	**Met**
	Action taken as confirmed during the inspection: Details of the investigation findings were recorded within the QIP response, which was received by RQIA on 19 November 2014.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	There should be an increase in the level of audit of liquid formulations, in order to ensure their administrations are in compliance with the prescribed instructions.	**Met**
	Action taken as confirmed during the inspection: A running stock balance was maintained for liquid medicines and these balances were spot checked on a regular basis.	
Recommendation 2 **Ref**: Standard 37 **Stated:** First time	Staff roles with respect to the applications of topical medicines should be reviewed.	**Met**
	Action taken as confirmed during the inspection: This area of medicines management had been further developed. Training had been provided and care staff were aware of their roles and responsibilities in administration and record keeping. The format of records had been revised. Most of the records were well maintained and their completion was overseen by senior care staff. This was discussed in relation to ensuring that any delegated medicines tasks were also overseen by registered nurses. The assistant manager advised that some more progress was needed in this area and that this would be addressed through management audit.	
Recommendation 3 **Ref**: Standard 37 **Stated:** First time	The arrangements for the disposal of controlled drugs (including Schedule 4, Part 1 controlled drugs) should be reviewed to ensure that there is evidence they were denatured prior to disposal.	**Met**
	Action taken as confirmed during the inspection: Examination of the disposal of medicines records indicated that where a medicine had been denatured prior to disposal, this was clearly stated. This included Schedule 4 controlled drugs.	

Recommendation 4 **Ref**: Standard 38 **Stated:** First time	In the general nursing unit, the disposal of all controlled drugs should be documented in the disposal of medicines record and two staff should routinely sign the entries.	**Met**
	Action taken as confirmed during the inspection: Examination of the disposal records indicated that two registered nurses were involved in the disposal of medicines. Their initials or signatures were recorded.	

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 supervision and annual appraisal. Competency assessments were completed annually. Refresher training had been 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.

The management of high risk medicines e.g. warfarin and insulin was reviewed. Separate administration records were in use and care plans were maintained. It was suggested that the day of the week be added to the warfarin administration record and also two staff should initial any transcribing on these records. It was agreed that this would be implemented with immediate effect.

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

Discontinued or expired medicines were disposed of appropriately.

Most medicines were stored safely and securely and in accordance with the manufacturer's instructions. However, some external preparations, eye drops, injections, glucose preparations and opened insulin pens were stored at the incorrect temperature. These were highlighted at the inspection. A requirement was made.

Whilst the medicine storage areas were tidy and organised, several opened external preparations were stored together in a box; they were not stored in the original manufacturer's outer box. For one rectal medicine, the rectal tube remained attached to the external preparation and was stored with other external preparations. In relation to infection control and cross-contamination of external preparations, this area of medicines management should be reviewed. A requirement was made.

A small number of eye drops did not state the date of opening and some others had expired. There was no evidence that these had been administered after the expiry date had been reached and were removed from stock. It was agreed that eye preparations would be included in the audit process.

In relation to the domain of safe care, all but one of the questionnaire responses from patients, relatives/patient representatives and staff were recorded as 'very satisfied' or 'satisfied' with the management of medicines in the home. One response was recorded as 'unsatisfied'; the details related to the care of patients. These were shared with the regional manager for attention and also with the care inspector for the home.

Areas for improvement

The necessary arrangements must be made to ensure that all medicines are stored at the temperature specified by the manufacturer. A requirement was made.

The storage arrangements for medicines must be reviewed with respect to infection control and cross contamination. A requirement was made.

Number of requirements	2	**Number of recommendations**	0

4.4 Is care effective?

The majority of medicines had been administered in accordance with the prescriber's instructions. Some audit trails could not be completed due to the incompletion of medicine records, as detailed below.

There were largely satisfactory arrangements in place to alert staff of when doses of mid-weekly, weekly, monthly or three monthly medicines were due. The medicine administration records had been marked out to indicate the day of administration. This is best practice. However, it was noted that two pain controlling patches had been administered one day late in the last few days and was discussed. There was no evidence that the patient had expressed any pain during the delay. Staff confirmed that an incident form had been completed and forwarded to us.

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 management of pain was examined. Staff advised that a pain assessment was completed for all patients in the home, at the time of admission and also on a regular basis. Pain management was detailed in the sample of care plans examined. These were reviewed each

month. With the exception of the patches discussed above, the sample of records examined indicated that pain controlling medicines had been administered as prescribed. Staff were aware of the need to ensure that the pain was well controlled and the patient was comfortable. A record of the reason for and the outcome of the administration were recorded. This is best practice.

The management of swallowing difficulty was examined. Staff were knowledgeable regarding this area of medicines management and each patient's needs. For those patients prescribed a thickening agent, this was recorded on their personal medication record and usually included details of the fluid consistency. Each administration was recorded and care plans and speech and language assessment reports were in place. Staff were reminded that the fluid consistency should also be recorded on the administration records completed by care staff.

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.

The majority of medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the separate administration records for high risk medicines, transdermal patches and nutritional supplements. The audit trails on a small number of medicines could not be concluded as a record of receipt had not been fully or accurately maintained. Where medicines are supplied in seven day packs, a receipt record must be made for each medicine and on each occasion that a supply is received. The record must be dated. A recommendation was made. Staff were reminded that all medicines must be clearly identifiable in these packs.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to medicines management.

In relation to the domain of effective care, the majority of questionnaire responses from patients, relatives/patient representatives and staff and were recorded as 'very satisfied' or 'satisfied' with the management of medicines in the home. One questionnaire response was recorded as 'unsatisfied' in relation to medicines management and care. At the time of the medicines management inspection, there was no evidence to support the comments made. However, the comments were shared with the regional manager for attention and also with the care inspector for the home.

Areas for improvement

A detailed record of all incoming medicines should be 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, patients were given time to take their medicines and medicines were administered as discreetly as possible.

Patients advised that they had no concerns regarding the management of their medicines and stated that staff responded to any requests that they had e.g. pain relief. One patient expressed how staff were very punctual regarding times of administration of their medicines.

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.

There was evidence of good relationships between the staff and the patients. The staff were friendly and courteous to the patients.

In relation to the domain of compassionate care, the questionnaire responses from patients, relatives/patient representatives and staff 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. These were not examined at the inspection. 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 variety of auditing systems for medicines management were in place. Daily, weekly, monthly and quarterly audits were completed. They included running stock balances for several medicines which were not included in the 28 day monitored dosage medicine system e.g. liquids, analgesics, laxatives and inhaled medicines; a quarterly audit was also completed by the community pharmacist. Any areas for improvement were highlighted and an action plan developed. In addition, staff advised that each day, two patients' records were selected and audited in relation to medicines, care plans and assessments. As issues regarding the storage of medicines were highlighted, it was suggested that the audit process should be further developed.

As part of the governance processes in the home, staff advised that a weekly head of department meeting was held.

Following discussion with the assistant manager, registered nurses and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. The registered nurses confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff through meetings, supervision and a shift handover.

During the inspection, a number of care staff raised concerns regarding the leadership and management in the home. Whilst they reiterated that they felt supported by their peers and

the registered nurses, some stated they did not have good relationships with management. These issues were raised with the assistant manager at feedback with the consent of care staff who advised she would look into these. They were also shared with the regional manager who confirmed that these would be investigated and a response forwarded to us.

In relation to the domain of a well led service, four questionnaire responses from patients, relatives/patient representatives and staff, were recorded as 'very satisfied' or 'satisfied' with the management of medicines in the home. However, four other responses were recorded as 'unsatisfied'. There was no detail recorded in three responses and the detail recorded in the fourth response was not in relation to the management of medicines; these responses were shared with the regional manager for attention and also with the care inspector.

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 Patricia Amaral, Assistant Manager, and Ms Karen McElherron, Regional 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 pharmacists@rqia.org.uk 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:** 9 March 2017	The registered provider must ensure that all medicines are stored in strict accordance with the manufacturers' instructions.
	Response by registered provider detailing the actions taken:
Requirement 2 **Ref**: Regulation 13(7) **Stated:** First time **To be completed by:** 9 March 2017	The registered provider must review the infection prevention issues as identified at the inspection to ensure they are managed to minimise the risk and spread of infection.
	Response by registered provider detailing the actions taken:
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 9 March 2017	The registered provider should ensure that records for the receipt of medicines are fully and accurately maintained.
	Response by registered provider detailing the actions taken:

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address

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