Unannounced Medicines Management Inspection Report
25 July 2016

Carlingford Lodge Care Home

Type of Service: Nursing Home
Address: 76 Upper Dromore Road, Warrenpoint, BT34 3PN
Tel No: 028 4175 9200
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Carlingford Lodge Care Home took place on 25 July 2016 from 09:30 to 15:15.

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?
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. Recommendations were made relating to the accurate recording of thickening agent consistencies in care plans and the recording of the route of application of eye-treatment medicines on the personal medication records and medicine administration records.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Bijini John, Nurse 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 previous QIP, there were no further actions required to be taken following the last inspection on 14 and 15 June 2016.

2.0 Service details

Registered organisation/registered person: Priory (Warrenpoint) Ltd/ Mrs Caroline Denny	**Registered manager:** See box below
Person in charge of the home at the time of inspection: Ms Bijini John	**Date manager registered:** Ms Bijini John, registration pending
Categories of care: NH-DE, NH-I	**Number of registered places:** 74

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

During the inspection the inspector met with three patients, the nurse manager and four registered nurses.

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
- 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 and 15 June 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be reviewed care inspector following its return to RQIA. This QIP will be validated by the care inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 18 November 2013

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must submit monthly written reports to RQIA for the months of November 2013, December 2013 and January 2014, detailing the outcomes of the medicines management audit activity within the dementia unit.	**Met**
	Action taken as confirmed during the inspection: The monthly audit reports were forwarded as requested.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	A care plan should be in place where medication is covertly administered to a patient.	**Met**
	Action taken as confirmed during the inspection: A care plan was in place where there was the possibility of medication having to be covertly administered to a patient.	
Recommendation 2 **Ref**: Standard 38 **Stated:** First time	Care staff should record the use of thickening agents.	**Met**
	Action taken as confirmed during the inspection: Care staff recorded the use of thickening agents on the food and fluid intake charts.	

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 team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was provided within 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 medicine 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.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. 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.

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. Medicine refrigerators and oxygen equipment were checked at regular intervals. Insulin pens were not dated when first used; the nurse manager gave an assurance that this would be rectified without delay.

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 sample of medicines examined had largely been administered in accordance with the prescriber's instructions. A couple of discrepancies were drawn to the attention of the nurse manager, who gave an assurance that the medicines would be closely monitored.

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 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. 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 sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff advised that a pain assessment was completed as part of the admission process. A pain assessment tool was completed and updated as necessary. A care plan was maintained and it was evaluated on a monthly basis. 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, this was recorded on their personal medication record and medicine administration record and included details of the fluid consistency. Administrations were recorded. Speech and language assessment reports were in place. However, the fluid consistencies recorded on the care plans were inaccurate; a recommendation was made.

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 mostly well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included additional records for insulin, transdermal patches and warfarin. For most eye-treatment medicines, the route of application was not recorded on the personal medication records or medicine administration records; a recommendation was made. In the dementia unit, the removals of lidocaine patches had generally not been recorded; the nurse manager gave an assurance that this matter would be rectified without delay.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for most solid dosage medicines not contained in the monitored dosage system blister packs. In addition, a quarterly audit was completed by the community pharmacist. The dates and times of opening of the medicine containers were recorded in order to facilitate audit; this was acknowledged as good practice.

Following discussion with the registered manager and staff, it was evident that there were good working relationships with other healthcare workers, including the community pharmacist and prescribers.

Areas for improvement

Where a patient is prescribed a thickening agent, the fluid consistency should be accurately recorded in the care plan; a recommendation was made.

The route of application of eye-treatment medicines should be routinely recorded; a recommendation was made.

Number of requirements	0	Number of recommendations:	2

4.5 Is care compassionate?

The administration of medicines to several patients in the dementia unit was observed during the inspection. Medicines were administered to the patients in the living room or in their room. The nurses administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to swallow each medicine. Extra time and attention was given to patients who had difficulty swallowing some of the medicines. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff and patient interaction and communication demonstrated that patients were treated courteously, with dignity and respect. Good relationships were evident.

The patients spoken to advised that they had no concerns in relation to the management of their 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. Following discussion with staff, it was evident that they were knowledgeable of the policies and procedures and that any updates were highlighted to them.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report 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.

Following discussion with the nurse manager and registered nurses, it was evident that staff had a good knowledge of 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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Bijini John, Nurse 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 taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to *pharmacists@rqia.org.uk* for review 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	
Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 24 August 2016	The registered provider should ensure that the fluid consistency of a thickening agent is accurately recorded in the patient's care plan.
	Response by registered provider detailing the actions taken: I can confirm that the fluid consistency has been recorded appropriately in the kardex and care plan . Home manager will monitor compliance to ensure care plans reflect changes following any SALT assessments.
Recommendation 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 24 August 2016	The registered provider should ensure that the route of application of eye-treatment medicines is routinely recorded.
	Response by registered provider detailing the actions taken: This has been addressed and compliance will be monitored by the home manager .

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