Unannounced Medicines Management Inspection Report
21 June 2017

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

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 74 beds that provides care for patients of old age or who are living with dementia.

3.0 Service details

Organisation/Registered Provider: Amore (Warrenpoint) Ltd **Responsible Individual:** Mrs Nicola Cooper	**Registered Manager:** See box below
Person in charge at the time of inspection: Ms Sara Main	**Date manager registered:** Ms Sara Main – Acting- No application required
Categories of care: Nursing Care (NH) I - Old age not falling within any other category DE – Dementia	**Number of registered places:** 74 Comprising a maximum of 41 persons in category NH-I and 33 persons in category NH-DE.

4.0 Inspection summary

An unannounced inspection took place on 19 June 2017 from 09.40 to 14.35.

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.

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 medicine administration, medicine records and storage.

An area requiring improvement was identified regarding ensuring that there is a continuous supply of medicines for newly admitted patients.

Patients said they were satisfied with the care they received.

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	1	0

Details of the Quality Improvement Plan (QIP) were discussed with Ms Sara Main, 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

Other than those actions detailed in the QIP no further actions required to be taken following the most recent inspection on 9 May 2017.

Following this inspection a serious concerns meeting was held in the Regulation and Quality Improvement Authority (RQIA) Belfast Office on 15 May 2017 with representatives from Amore (Warrenpoint) Ltd., to discuss the areas for improvement identified. At this meeting, a full account of the actions taken was provided and RQIA decided to give the management of the home a period of time to address the concerns and drive the necessary improvement.

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.

During the inspection the inspector met with three patients and four staff. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff. A total of 15 questionnaires were provided for completion and return to RQIA.

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
- care plans
- training records
- medicines storage temperatures

Areas for improvements 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 9 May 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be reviewed 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 25 July 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 4 **Stated:** First time	The registered provider should ensure that the fluid consistency of a thickening agent is accurately recorded in the patient's care plan.	**Met**
	Action taken as confirmed during the inspection: For those records examined, the thickening agent consistency was accurately recorded in the patients' care plans.	
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time	The registered provider should ensure that the route of application of eye-treatment medicines is routinely recorded.	**Met**
	Action taken as confirmed during the inspection: For those eye-treatment medicines examined, the route of application was recorded.	

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 was provided in the last year.

Systems were generally in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. However, two recently admitted patients each had two medicines out-of-stock (for between one and three days). The registered nurses confirmed that these medicines had been requested and were expected to be delivered that day; one of the medicines arrived in the home during the inspection. A continuous supply of medication must be maintained for newly admitted patients.

Antibiotics and newly prescribed medicines had been received into the home without delay.

In each unit, prescription forms awaiting uplift by the community pharmacy were stored in a poly-pocket that was attached to the wall at the nurses' station. This arrangement is not secure. The manager gave an assurance that the arrangements for the storage of prescription forms would be reviewed without delay to ensure they are secure.

There were satisfactory arrangements in place to manage changes to prescribed medicines. For several patients recently admitted to the home whose records were examined, the medicine records correlated with the medication profiles received on admission. Personal medication records and handwritten entries on medicine administration records were updated by two registered nurses. This safe practice was acknowledged.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. These had normally been maintained in a satisfactory manner. However, on 20 June 2017, the administrations of two doses of a controlled drug to a patient in the dementia unit had not been recorded in the controlled drug record book. This observation was discussed with the manager, who agreed to report these recording omissions as an incident to RQIA and to notify the nursing agency that supplied the nurse responsible for the omissions. 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 at regular intervals.

Areas of good practice

There were examples of good practice in relation to staff training and competency assessments and the management of high risk medicines.

Areas for improvement

A continuous supply of medication must be maintained for newly admitted patients.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

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

The sample of medicines examined had been administered in accordance with the prescriber's instructions. 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. The reason for and the outcome of administration were generally 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 were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. A pain assessment tool was used as needed and a care plan was maintained. Staff advised that a pain assessment is 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. Administrations were 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.

Medicine records were generally well maintained and facilitated the audit process. Areas of good practice were acknowledged and included recording the date of replacement of medicine containers. For one patient in the general nursing unit, the removals of lidocaine patches were not recorded. The 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 and some inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the acting manager and staff, it was evident that, when applicable, other healthcare professionals were contacted in response to the healthcare needs of patients. Staff on duty advised that they had good working relationships with the community pharmacy, GP practices and the Health and Social Care Trust.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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; patients were given time to take their medicines and medicines were administered as discreetly as possible.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were noted to be friendly, courteous and happy in their work; they treated the patients with dignity.

Patients spoken to advised that they were satisfied with the care they received. 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.

As part of the inspection process, we issued questionnaires to patients, patients' representatives and staff. Four patients and three patient's representatives completed and returned questionnaires within the specified timeframe. With one exception, comments received were positive; with responses recorded as 'very satisfied' or 'satisfied' with the management of medicines in the home. However, one relative expressed dissatisfaction regarding a couple of aspects of care. The concerns were shared with the manager for further review and consideration.

Four members of staff also completed a questionnaire. The responses were positive and raised no concerns about the management of medicines in the home.

Areas of good practice

Staff listened to patients and took account of their views.

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. Following discussion with staff it was evident that they were familiar with 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. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding lead and 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 manager and registered nurses, 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 of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

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 Ms Sara Main, 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 QIP to Pharmacists@rqia.org.uk for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 21 July2017	The registered person shall ensure that a continuous supply of medication is maintained for newly admitted patients. Ref: 6.4
	Response by registered person detailing the actions taken: Family informed on preaddmission to ensure adequate supply of medication throughout respite period. When patient is admitted, GP to be contacted and new prescription to be arranged as necessary. Boots to be informed via new service user update form.

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

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