Unannounced Medicines Management Inspection Report
29 November 2016

Ardlough

Type of Service: Nursing Home
Address: 2 Ardlough Road, Drumahoe, Londonderry, BT47 5SW
Tel no: 028 7134 2899
Inspector: Helen Mulligan

1.0 Summary

An unannounced inspection of Ardlough took place on 29 November 2016 from 10:05 to 15:05.

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. Significant improvements in the management of medicines were noted at this inspection and the registered manager and staff were commended for their efforts.

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. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. There were no areas for 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. No areas for improvement were identified.

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	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Anne Martina Mullan, Registered Manager, and Ms Louisa Rea, Regional Manager, Four Seasons Healthcare, 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 care inspection

Other than those actions details in the QIP, there were no further actions required to be taken following the most recent inspection on 13 April 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/Dr Maureen Claire Royston	**Registered manager:** Mrs Anne Martina Mullan
Person in charge of the home at the time of inspection: Mrs Anne Martina Mullan	**Date manager registered:** 13 February 2014
Categories of care: NH-DE, NH-MP, NH-MP(E)	**Number of registered places:** 44

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.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and this invited visitors/relatives to speak with the inspector. The inspector spoke to one relative 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
- 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 13 April 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 specialist inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection 27 July 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The registered manager must ensure that bisphosphonate medicines are administered 30 minutes clear of food and other medicines in accordance with the manufacturer's instructions.	**Met**
	Action taken as confirmed during the inspection: Robust arrangements were in place to ensure bisphosphonate medicines were administered at the correct time.	
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered person must review and revise the management of medicines prescribed on a "when required" basis for the management of distressed reactions to ensure care plans are in place, records are adequately maintained and there is evidence of regular monitoring and review.	**Met**
	Action taken as confirmed during the inspection: The management of distressed reactions has been reviewed and revised. Care plans were in place, records of administration were well-maintained and there was evidence of regular review and monitoring.	

Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered person must ensure medicines dispensed in monitored dosage cassettes are disposed of after eight weeks.	**Met**
	Action taken as confirmed during the inspection: No out of date medicines were noted in the monitored dosage cassettes.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 38 **Stated:** Second time	The registered manager should ensure that records of the administration of thickening agents and topical medicines by non-nursing care staff are adequately maintained.	**Met**
	Action taken as confirmed during the inspection: Records were well-maintained. There was also evidence that the records were subject to regular review by registered nurses and the registered manager.	
Recommendation 2 **Ref**: Standard 28 **Stated:** First time	The registered person should ensure there are robust arrangements in place to audit all aspects of the management of medicines.	**Met**
	Action taken as confirmed during the inspection: Robust auditing and monitoring procedures were in place for the management of medicines.	

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 on 19 October 2016. The registered manager advised that the community pharmacist provides medicines management training for staff in the home on a quarterly basis. The registered manager also advised that Four Seasons Healthcare are currently implementing a Dementia Care Framework for all staff and training will be delivered in 2017.

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

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

Discontinued or expired medicines were disposed of appropriately. The majority of discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. Staff were reminded that all controlled drugs, including those in Schedule 4, should be denatured 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. Staff were reminded that spacer devices and masks for delivering doses of inhaled medicines should be kept covered when not in use.

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 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 recorded. A care plan was maintained and there was evidence this was subject to regular review and monitoring.

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 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 those patients prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Each administration was 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 well maintained and facilitated the audit process. Areas of good practice were acknowledged, including weekly checks on the controlled drugs book by the registered manager, daily checks on the administration of and recording of the administration of medicines for external use and thickening agents, records of the application and removal of controlled drug patches and protocols for the management of medicines prescribed on a "when required" basis.

Robust arrangements for monitoring and auditing medicines in the home were noted. Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several liquid and solid dosage medicines, nutritional supplements and inhaled medicines, weekly and monthly audits by the registered manager, nightly medicine audits by registered nurses and a weekly review of medicines prescribed on a "when required" basis. A 24 hour nursing report has been completed each day and this included details of any medicine management issues such as out of stock medicines. In addition, a quarterly audit was completed by the community pharmacist. On 24 November 2016, the registered manager completed an audit of all care plans in the home.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to the healthcare needs of patients in the home. One visiting healthcare professional was spoken to during the inspection. She reported on a good working relationship with the home and that she was "happy with the care provided in Ardlough".

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?

Appropriate arrangements were in place to facilitate patients responsible for the self-administration of medicines.

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.

Four patients spoke to the inspector and they advised:

"It's all very good here."
"I get medicine for pain – it works well."
"The food is as good as anywhere."
"I got my medicines today."
"The nurse gave me my 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.

One relative was spoken to during the inspection. The relative advised, "I am very happy with my mother's care. I've never seen her dirty. I am encouraged to talk to the manager and staff if I have any problems, before I leave the home."

Ten staff questionnaires, five relative/visitor questionnaires and 10 questionnaires for patients were left in the home to facilitate feedback from staff, patients and relatives/visitors.

Seven staff questionnaires were returned and all respondents advised they were satisfied or very satisfied that care was safe, effective and compassionate and the service was well led with respect to the management of medicines.

At the time of writing, three relative's questionnaire had been returned; the relatives advised they were very satisfied with the care provided. One relative felt that staff could not always spend enough time with their relative, but acknowledged that "they do their best and she does get brilliant care now."

Six patient questionnaires were returned and all respondents advised they were either satisfied or very satisfied with the way their medicines were managed.

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 on a regular basis. Policies and procedures were last updated in January 2016. 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. The registered manager advised that staff are also encouraged to report any "near misses" relating to medicines management.

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.

The requirements and recommendations made at the last medicines management inspection had been addressed

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff through regular supervision and staff 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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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