Unannounced Medicines Management Inspection Report
7 June 2018

Culmore Manor Care Centre

Type of Service: Nursing Home
Address: 39 Culmore Road, Londonderry, BT48 8JB
Tel No: 028 7135 9302
Inspector: Judith Taylor

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 56 beds that provides care for patients living with healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Larchwood Care Homes (NI) Ltd **Responsible Individual:** Mr Christopher Walsh	**Registered Manager:** Mr Ciaran Burke
Person in charge at the time of inspection: Ms Caroline McCutcheon (Deputy Manager)	**Date manager registered:** 28 December 2012
Categories of care: Nursing Homes (NH): I – Old age not falling within any other category PH – Physical disability other than sensory impairment	**Number of registered places:** 56 comprising: NH-I - maximum of 46 patients NH-PH - maximum of 10 patients

4.0 Inspection summary

An unannounced inspection took place on 7 June 2018 from 10.20 to 15.30.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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 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 the governance arrangements, training, the completion of most records, the administration of medicines and the management of controlled drugs.

Two areas for improvement were identified in relation to self-administration and limited shelf medicines.

Patients said they were happy in the home and spoke positively about the management of their medicines and the care provided by staff. We noted the warm and welcoming atmosphere in the home.

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	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Ms Caroline McCutcheon, Deputy Manager; and Mr Chris Walsh, Responsible Individual on 8 June 2018, 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

No further actions were required to be taken following the most recent inspection on 25 January 2018. Enforcement action did not result from the findings of this inspection

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.

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection we met with three patients, two registered nurses, three care staff and the deputy manager.

Ten questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

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

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 25 January 2018

The most recent inspection of the home was an unannounced care inspection. There were no areas for improvement identified as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 6 June 2016

There were no areas for improvement identified as a result of the last medicines management inspection.

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. A process was in place to ensure that all staff were kept up to date with training in medicines management. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training was completed each year.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and for the management of medicines changes. Written confirmation of medicine regimes and new medicine dosages was in place. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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. Care plans were maintained.

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 organised. The management of medicines with a limited shelf life once opened was examined. The date of opening was recorded on some but not all of the eye preparations and insulin pens in use. A few eye preparations were removed for disposal and it was agreed that one insulin pen would be replaced. An area for improvement was identified. 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, competency assessment, the management of medicines on admission/medicine changes and controlled drugs.

Areas for improvement

The management of limited shelf life medicines should be reviewed to ensure that the date of opening is recorded to enable staff to identify when the medicine should be replaced.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

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

Most of the sample of medicines examined had been administered in accordance with the prescribers' instructions. A few discrepancies were noted and discussed for close monitoring. This was to be commenced from the day of the inspection. It was suggested that a running stock balance should be maintained for these medicines e.g. inhaled medicines.

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 medicines administered at weekly, monthly and three monthly intervals were due; reminders were marked out on the medication administration records and also displayed in each treatment room.

The management of medicines prescribed for pain, distressed reactions and swallowing difficulty was reviewed. The dosage directions were clearly marked on the personal medication records. Care plans were in place. Administration was recorded.

Overall, the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for transdermal patches and high risk medicines. Staff were reminded that when a 'variable dose' is prescribed, the actual dose administered should be recorded on each occasion; and also, when a medicine was omitted and marked as 'withheld', more details should be recorded. Staff provided details at the inspection. In relation to the printed medication administration records, the times on these were recorded as meal times, e.g. breakfast, lunch. The actual time of administration

should be recorded. It was acknowledged that staff kept a record to show the time when analgesics were administered and so that staff could ensure the correct time intervals between doses were maintained. The actual time of administration was handwritten for time critical medicines. It was agreed that this would be raised with the community pharmacist for review.

The management of self-administered medicines was reviewed. A small number of patients administer some of their medicines. Risk assessments were in place for the patients, but only one of these was up to date and accurate. An area for improvement was identified.

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.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several analgesics and liquid medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with staff and a review of the care files, it was evident that when applicable, other healthcare professionals were contacted in response to the patient's healthcare needs.

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. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

The self-administration of medicines should be reviewed to ensure that this is accurately recorded in the risk assessment and compliance is monitored on a regular basis.

	Regulations	Standards
Total number of areas for improvement	0	1

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 not observed at this inspection. Following discussion with staff it was evident that patients were administered their medicines in a caring manner and were given time to take their medicines. They also advised that some medicines were administered later in the morning to accommodate the patient e.g. if they preferred to have a longer sleep.

Throughout the inspection, it was found that there were good relationships between the staff, patients and patients' visitors. Staff were noted to be friendly and courteous; they treated the patients with dignity. It was clear from discussion and observation of staff, that they were familiar with the patients' likes and dislikes.

We noted the warm and welcoming atmosphere in the home. Two patients were enjoying listening to a staff member reading out the newspaper. Two other patients were outside enjoying the weather. A birthday cake was also being shared.

We met with three patients, who expressed their satisfaction with the staff and the care provided. They advised that they were administered their medicines on time and any requests e.g. for pain relief, were adhered to. They stated they had no concerns at all. Comments included:

"I do feel well looked after."
"They (staff) are good to me; they always get me my medicines or anything I need."
"I am happy here; the girls are very good."
"The food is lovely, I always eat everything."

Of the questionnaires which were left in the home to facilitate feedback from patients and their representatives, none were returned within the time frame (two weeks). Any comments in questionnaires received after the return date will be shared with the registered manager as necessary.

Areas of good practice

Staff listened to patients and relatives 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.

The inspector discussed arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. There were arrangements in place to implement the collection of equality data in Culmore Manor.

Written policies and procedures for the management of medicines were in place. These were not examined at the inspection. Staff confirmed that there were procedures in place to ensure that they were made aware of any changes.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents and provided details of the procedures in place to ensure that all staff were made aware of incidents and to prevent recurrence. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the 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 staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with the registered manager; and any resultant action was discussed at team meetings and/or supervision.

We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date. In addition to the diary, a daily communication book was in use; in relation to medicines management, this included details of the patients prescribed antibiotics, new medicines or changes in medicine doses.

Although the staff spoke positively about their work and the relationships between staff and the patients, a number of staff raised concerns about the staffing levels in the home and were of the opinion that they didn't have enough staff on duty to complete their tasks, in a timely manner. They stated that they had raised these concerns on several occasions with the registered manager but they had not been addressed. They also raised a concern regarding a hoist which they stated had been broken for some time. These issues were discussed with the responsible individual for his attention and action as required; and also with the care inspector for the home.

No online questionnaires were completed by staff within the specified time frame (two weeks).

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 Caroline McCutcheon, Deputy Manager and Mr Chris Walsh, Responsible Individual, 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 via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 7 July 2018	The registered person shall review the management of limited shelf life medicines to ensure the date of opening is recorded. Ref: 6.4
	Response by registered person detailing the actions taken: Process now in place to ensure that the date of opening of limited shelf life medicines is recorded.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 7 July 2018	The registered person shall review the management of self-administered medicines to ensure accurate risk assessments are maintained and a system is in place to monitor compliance. Ref: 6.5
	Response by registered person detailing the actions taken: Risk assessments are in place and monitored in relation to self-administered medicines.

Please ensure this document is completed in full and returned via the Web Portal

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