Unannounced Medicines Management Inspection Report
6 June 2016

Culmore Manor Care Centre

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

1.0 Summary

An unannounced inspection of Culmore Manor Care Centre took place on 6 June 2016 from 09:25 to 14:20.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern.

Is care safe?

No requirements or recommendations have been made.

Is care effective?

No requirements or recommendations have been made.

Is care compassionate?

No requirements or recommendations have been made.

Is the service well led?

No requirements or recommendations have been 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.

Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008. Please refer to sections 4.2 of this report.

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 Mr Ciaran Burke, Registered Manager, 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 detailed in the previous QIP there were no further actions required to be taken following the last inspection on 25 April 2016.

2.0 Service details

Registered organisation/registered provider: Larchwood Care Homes (NI) Ltd / Mr. Christopher Walsh	**Registered manager:** Mr. Ciaran Burke
Person in charge of the home at the time of inspection: Mr. Ciaran Burke	**Date manager registered:** 28 December 2012
Categories of care: NH-PH, NH-I	**Number of registered places:** 56

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 six patients, the deputy manager and three registered nurses.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector. No-one availed of this opportunity.

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 25 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 care inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 14 April 2014

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should maintain a daily stock balance for warfarin.	**Met**
	Action taken as confirmed during the inspection: Daily stock balances were maintained for warfarin.	
Recommendation 2 **Ref**: Standard 37 **Stated:** First time	The registered manager should develop a list of the names, signatures and sample initials of the care staff who are trained and deemed competent, in delegated medicine related tasks.	**Met**
	Action taken as confirmed during the inspection: A list was maintained of the names, signatures and sample initials of the care staff who are trained and deemed competent in delegated medicine related tasks.	
Recommendation 3 **Ref**: Standard 38 **Stated:** First time	The registered manager should ensure that two nurses/suitably trained staff are involved in the disposal of each medicine and both persons should sign the disposal record.	**Met**
	Action taken as confirmed during the inspection: From discussion with staff and examination of the disposal of medicines record, it was concluded that two registered nurses disposed of medicines and signed the disposal record.	

Recommendation 4 **Ref**: Standard 37 **Stated:** First time	The registered manager should review the management of distressed reactions to ensure the relevant records are maintained.	**Met**
	Action taken as confirmed during the inspection: When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, a care plan was maintained. The reason for and the outcome of administration were generally recorded.	

4.3 Is care safe?

Medicines were managed by staff who had been trained and deemed competent to do so. An induction process was in place. Refresher training in medicines management was provided annually; the last training session was on 10 December 2015. Care staff had received training in the use of thickening agents and the application of external medicines. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed at the end of the induction period and annually thereafter.

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 patients' admissions to and discharges from 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; this was acknowledged as good practice.

Robust arrangements were observed for the management of high risk medicines e.g. insulin and warfarin.

Appropriate arrangements were in place for the management of medicines which were administered via an enteral feeding tube.

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 manufacturers' instructions. Medicine storage areas were clean, tidy and well organised. Medicine refrigerators and oxygen equipment were checked at regular intervals.

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. Arrangements were in place to alert staff of when doses of weekly, monthly 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 parameters for administration were recorded on the personal medication record. A care plan was maintained. The reason for and outcome of administration had mostly been recorded. 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 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 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. The thickening agent was recorded on the patient's personal medication record and the details of the fluid consistency were mostly recorded. Administrations were generally recorded and a care plan and a speech and language assessment report 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 maintained in a satisfactory manner and facilitated the audit process.

Practices for the management of medicines were audited throughout the month by the management and staff. 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 nursing staff and a review of care files, it was evident that, when applicable, other healthcare professionals were contacted in response to issues or concerns in relation to medicines management

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?

The administration of medicines to several patients was observed during the inspection. Medicines were administered to patients in the dining room or in their rooms. The registered 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.

The patients spoken to advised that they had no concerns in relation to the management of their medicines, and their requests for medicines prescribed on a "when required" basis was adhered to e.g. pain relief.

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 these policies and procedures and that any updates were highlighted to them by management.

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 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 staff, it was evident that they 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 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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