Unannounced Medicines Management Inspection Report
20 October 2016

Edenvale Care Home

Type of Service: Nursing Home
Address: 1-7 Edenmore Road, Limavady, BT49 0RF
Tel no: 028 7772 2055
Inspector: Judith Taylor

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Edenvale Care Home took place on 20 October 2016 from 10.15 to 15.10.

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?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines had been trained and deemed 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. No requirements or recommendations were made.

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. Medicine records were well maintained. Care plans in relation to medicines management were in place. No requirements or recommendations were made.

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. The patient consulted with confirmed that they were administered their medicines appropriately. No requirements or recommendations were made.

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 was evidence of a robust auditing system for medicines management. No requirements or recommendations were 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.

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 Carol Craig, 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 QIP there were no further actions required to be taken following the most recent inspection on 6 April 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/ Dr Maureen Claire Royston	**Registered manager:** Mrs Carol Craig
Person in charge of the home at the time of inspection: Mrs Carol Craig	**Date manager registered:** 14 August 2009
Categories of care: NH-LD, NH-MP, NH-MP(E), NH-PH, NH-TI, NH-DE, NH-I, NH-PH(E)	**Number of registered places:** 55

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

We met with one patient, two members of care staff, three registered nurses and the registered manager.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

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 6 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 19 November 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 29 **Stated:** First time	The completion of medication administration records should be reviewed to ensure that the entries are legible, accurate and auditable.	**Met**
	Action taken as confirmed during the inspection: An improvement in the completion of medication administration records was noted. These records were well maintained.	
Recommendation 1 **Ref**: Standard 18 **Stated:** First time	When medicines are prescribed on a "when required" basis, for the management of distressed reactions, a detailed care plan should be maintained and the effect of the administration should be recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: The relevant care plan and records were maintained for patients prescribed medicines for the management of distressed reactions.	

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, agency 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. A sample of training records was provided at the inspection. Competency assessments were completed annually. Refresher training in medicines management was provided annually.

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 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. 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 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 three times weekly, weekly or three monthly medicines were due.

When a patient was prescribed a medicine for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. A care plan and protocol were maintained. 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.

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 assessment tool was used as needed. A care plan and protocol were maintained. Staff also advised that a pain assessment was completed as part of the patient's 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 a care plan and speech and language assessment report was 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. The good standard of record keeping was acknowledged. Good practice included the use of separate administration records for warfarin, transdermal patches and insulin. As part of a recently identified area for improvement, new administration records regarding external preparations were in the process of being implemented.

Practices for the management of medicines were audited throughout the month by the staff and management. This included daily running stock balances for the majority of medicines, including liquid medicines, nutritional supplements and inhaled medicines; and a weekly audit of thickening agents, insulin and eye preparations. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager, staff and a review of care records, it was evident that when applicable, other healthcare professionals were contacted in response to issues or concerns regarding 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 was not observed at the time of the inspection. Following discussion with staff, it was ascertained that medicines were administered to patients 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. Patients were treated courteously, with dignity and respect. Good relationships were evident.

The patient spoken to at the inspection advised that they were content with their care in the home and the management of their medicines and was complimentary about the staff and the food in the home.

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. These had been reviewed earlier this year. Staff were familiar with the policies and procedures.

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 internal audit records indicated that largely satisfactory outcomes had been achieved. The registered manager provided details of the areas for improvement which had been recently identified and how these were being addressed. She also advised that any areas for improvement were communicated to staff via a specific electronic messaging system, which staff view at the start of their shift. She provided examples and advised that this system was working well.

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.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated to them individually, through supervision or at 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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