Edenvale Care Home
RQIA ID: 1182
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Limavady
BT49 0RF

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Unannounced Medicines Management Inspection of Edenvale Care Home

19 November 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced medicines management inspection took place on 19 November 2015 from 10.10 to 16.00.

The management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no significant areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

This inspection was underpinned by the DHSSPS Care Standards for Nursing Homes, April 2015.

Recommendations made as a result of this inspection relate to 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.

1.1 Actions/Enforcement Taken Following the Last Medicines Management Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last inspection on 6 March 2013.

1.2 Actions/Enforcement Resulting from This Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

The details of the QIP within this report were discussed with Mrs Carol Craig, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care 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
Number of Patients Accommodated on Day of Inspection: 52	**Weekly Tariff at Time of Inspection:** £603 - £608

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and to determine if the following standards and themes have been met:

Standard 28: Management of Medicines
Standard 29: Medicines Records
Standard 31: Controlled Drugs

Theme 1: Medicines prescribed on a “when required” basis for the management of distressed reactions are administered and managed appropriately

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately

4. Methods/Process

Specific methods/processes used included the following:

We reviewed the management of medicine related incidents reported to RQIA since the last medicines management inspection.

We met with the registered manager and the registered nurses on duty.

The following records were examined:

- medicines requested and received
- personal medication records
- medicines administration records
- medicines disposed of
- medicines transferred
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicine storage temperatures

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 18 September 2015. The completed QIP was assessed and approved by the care inspector on 26 October 2015.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Inspection

Last Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must review the standard of maintenance of record keeping with regard to medicine changes, to ensure medicine records are clear and unambiguous.	**Met**
	Action taken as confirmed during the inspection: Details of medicine changes were clearly recorded on the medicine records. These had been signed and verified by the registered nurses.	
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must put robust arrangements in place for the management of eye drops.	**Met**
	Action taken as confirmed during the inspection: The outcomes of the audit trails indicated that eye drops were administered as prescribed and there were arrangements in place to ensure these were replaced once the in use expiry date had been reached.	

Last Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref:** Standard 39 **Stated:** Second time	The registered manager should closely monitor the management of limited shelf life medicines to ensure robust arrangements are in place.	**Met**
	Action taken as confirmed during the inspection: These medicines were included in the audit process and the date of opening was recorded**.**	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

Several medicines and medicine records were audited at the inspection. The audits produced satisfactory outcomes indicating that medicines were administered as prescribed. Bisphosphonate medicines had been administered in accordance with the manufacturers' instructions.

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. Care plans/protocols for the management of epileptic seizures were in place for the relevant patients.

Systems to manage the ordering of prescribed medicines to ensure adequate supplies were available were reviewed. These were found to be satisfactory. All of the medicines examined at the inspection were labelled appropriately.

There were satisfactory arrangements in place to manage medicine changes, including high risk medicines; all changes were confirmed in writing and records were updated by two registered nurses. This is safe practice.

Most of the medicine records were legible and accurately maintained so as to ensure that there was a clear audit trail. Some areas for improvement were identified in the records of the administration of medicines. Accurate codes should be used to indicate the reason for non-administration and the records must be legible and maintained to facilitate audit. A recommendation was made.

The receipt, storage, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Stock reconciliation checks were performed on controlled drugs which require safe custody, at each transfer of responsibility. Additional stock reconciliation checks were also performed on other controlled drugs which is good practice.

Discontinued or expired medicines were discarded into pharmaceutical clinical waste bins by two registered nurses. These waste bins were uplifted by a contracted waste disposal company. Staff confirmed that discontinued controlled drugs were denatured and rendered irretrievable prior to disposal using denaturing kits. It was advised that the relevant medicine records should clearly indicate this.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record. There were arrangements in place to ensure that staff were aware of each patient's prescribed fluid consistency. Each administration was recorded and a care plan and speech and language assessment report were in place.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines, including Standard Operating Procedures for controlled drugs were in place. These had been read and signed by the staff this year.

There was evidence that the staff responsible for medicines management had been trained and deemed competent. The impact of training was evaluated through supervision, appraisal and from the outcomes of the audit trails. General medicines management training was provided through the completion of e-learning modules and there were arrangements in place to provide additional training as needed.

Robust arrangements were in place to audit the management of medicines. A running stock balance was maintained for most medicines which is good practice. A daily, weekly and quarterly audit was completed. A review of the audit records indicated that largely satisfactory outcomes had been achieved and there was evidence of the action taken following the identification of a discrepancy. The audit process was facilitated by the good practice of recording the date and time of opening on the medicine container and recording the quantity of medicine carried forward from the previous medicine cycle.

The management of injectable medicines was reviewed and was found to be satisfactory.

Staff confirmed that compliance with prescribed medicines regimes was monitored and any omissions or refusals likely to have an adverse effect on the patients' health were reported to the prescriber.

There were systems in place to report and learn from any incidents that have occurred in the home. The reported medicine related incidents were discussed.

Is Care Compassionate? (Quality of Care)

The records pertaining to some patients who were prescribed medicines for the management of distressed reactions, on a "when required" basis, were observed. The name of the medicine and the frequency of dosing were recorded on the personal medication record. A care plan was maintained for some but not all of the patients. The reason for the administration was usually recorded; however, the outcome of the administration was not recorded. A recommendation was made. Staff were familiar with circumstances when to administer anxiolytic/antipsychotic medicines and had the knowledge 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 registered manager confirmed that a pain assessment was completed for all patients. The sample of records examined indicated that medicines which were prescribed to manage pain were recorded on the patient's personal medication record and 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 the patients could verbalise any pain. Pain assessment charts and care plans in relation to pain management were in place.

Areas for Improvement

The completion of medication administration records should be reviewed to ensure that the entries are legible, accurate and auditable. A recommendation was made.

In relation to the management of distressed reactions, a detailed care plan should be developed for any patient prescribed these medicines for administration on a "when required" basis; the outcome of the administration should be recorded on every occasion. A recommendation was made.

Number of Requirements	0	**Number of Recommendations**	2

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Carol Craig, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained 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 your premises. 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The DHPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The DHSSPS Care Standards for Nursing Homes (2015). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Person/Registered Manager

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to **pharmacists@rqia.org.uk** and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be Completed** 19 December 2015	The completion of medication administration records should be reviewed to ensure that the entries are legible, accurate and auditable.
	Response by Registered Person(s) Detailing the Actions Taken: staff have had supervision carried out with them in relation to this .Home manager continues to check the mediaction administration records .
Recommendation 2 **Ref**: Standard 18 **Stated:** First time **To be Completed by:** 19 December 2015	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.
	Response by Registered Person(s) Detailing the Actions Taken: staff have been informed of same and home manager continues at intervals to check records .Care plans have been implemented .

Registered Manager Completing QIP	Carol Craig	**Date Completed**	1.12.15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	11.12.15
RQIA Inspector Assessing Response	**Judith Taylor**	**Date Approved**	**15.12.15**

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