Unannounced Medicines Management Inspection Report
26 May 2016

Oakmont Lodge Care Home

Address: 267 - 271 Old Belfast Road, Bangor, BT19 1LU
Tel No: 028 9146 5822
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Oakmont Lodge Care Home took place on 26 May 2016 from 10:00 to 15:20.

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, though some minor areas for improvement were discussed and corrective action agreed. A quality improvement plan (QIP) was not issued.

Is care safe?
No requirements or recommendations were made.

Is care effective?
No requirements or recommendations were made.

Is care compassionate?
No requirements or recommendations were made.

Is the service well led?
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 Ms Lyndsey Paul, 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 inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the inspection on 25 January 2016.

2.0 Service details

Registered organisation/registered person: Maria Mallaband (9) Limited Mrs Victoria Craddock	**Registered manager:** Ms Lyndsey Paul
Person in charge of the home at the time of inspection: Ms Lyndsey Paul	**Date manager registered:** 4 December 2015
Categories of care: NH-DE, NH-I, NH-PH, NH-PH(E)	**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

The inspector met with one patient, two registered nurses and two care assistants.

A sample of the following records was examined:

- 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 January 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 25 January 2016

Last specialist inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** Second time	The registered person must ensure that accurate records of administration of emollient preparations and thickening agents are maintained.	**Partially Met**
	Action taken as confirmed during the inspection: Improvements in the records of administration were noted; however some omissions were observed. The registered manager advised that there had been a recent change in care staff. Training on the administration of thickening agents and emollients had been provided. Competency assessments were planned for the day of the inspection as evidenced in the daily plan. The registered manager gave assurances that she would closely monitor the standard of maintenance of these records and hence the requirement has not been restated.	
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must investigate the apparent discrepancies in the administration of three medicines for one patient. The outcome of the investigation including the action taken to prevent a recurrence must be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: The investigation had been completed and the outcome forwarded to RQIA.	
Last medicine management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 18 **Stated:** Second time	It is recommended that the reason for and outcome of each administration of "when required" anxiolytics is recorded.	**Met**
	Action taken as confirmed during the inspection: The records for two patients were examined. Care plans were in place. The medicines had not been administered to one patient. For the second patient the reason and outcome had been recorded for each administration.	

Recommendation 2 **Ref:** Standard 28 **Stated:** First time	The registered manager should review and revise the management of warfarin as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The management of warfarin had been reviewed and revised. Dosage directions were received in writing. Transcribing involved two staff and daily stock counts were carried out. The audit carried out at the inspection produced a satisfactory outcome.	

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 following induction and when a need was identified. Refresher training on medicines management had been provided in the last year. Registered nurses had attended training on the management of epilepsy and syringe drivers recently.

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 potential shortfalls in medicines. The registered manager attends the morning staff handovers and is therefore made aware of all medicine related issues; this is good practice.

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. The registered manager and one of the registered nurses on duty were reminded that the month and year must be recorded on all hand written medication administration records.

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. The use of separate administration charts was acknowledged. The date of opening had not been recorded on two insulin pens; the registered nurse advised that this had been an oversight. It was agreed that this finding would be highlighted to all registered nurses.

Arrangements were in place for administering medicines in disguised form to a small number of patients. There was evidence that this had been agreed with the prescriber and family. Whilst it was acknowledged that the registered nurses were aware of how each medicine was to be disguised and administered it was agreed that more detailed care plans would be written.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. The registered manager agreed to ensure that it would be clearly recorded that controlled drugs were denatured.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. However, due to recent admissions large overstocks of some medicines were observed. The registered manager advised that additional storage cupboards were on order and would be in place within two weeks. 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 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, 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.

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 their pain, and a pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment tool was 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. Care plans and speech and language assessments were in place. Registered nurses recorded each administration on the medication administration records. Separate recording sheets were available for care staff to record administration. The registered manager confirmed that the standard of maintenance of these records would be closely monitored to ensure that they are accurately maintained.

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. They included prompts for the administration of medicines outside the usual medicine rounds and transdermal patch sheets.

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

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

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.

We spoke with one patient who advised that he was very happy with how registered nurses managed his medicines. He stated that the care could not be better.

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 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.

A review of the home's 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 in a mostly satisfactory manner. One requirement had been only partially addressed; the registered manager gave assurances that it would be closely monitored to ensure that there was a sustained improvement and hence the requirement was not restated.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff by team meetings or supervisions.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

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 person/manager from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews