Unannounced Medicines Management Inspection Report
21 April 2016

Carrickfergus Manor

76 Dunluskin Gardens, Prince Andrew Way, Carrickfergus, BT38 7JA
Tel No: 028 9336 9780
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Carrickfergus Manor took place on 21 April 2016 from 09.30 to 15.00. The DeCourcey, Loughview and Knockagh units were inspected.

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 one area for improvement was identified and is set out in the quality improvement plan (QIP) within this report.

Is care safe?
No requirements or recommendations have been made.

Is care effective?
One recommendation has been made in relation to the recording of the reason for and outcome of the administration of medicines prescribed on a 'when required' basis for the management of distressed reactions.

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 as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015.

For the purposes of this report, the term 'patients' will be used to described those living in Carrickfergus Manor which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the QIP within this report were discussed with Mrs Joanne Neville, Registered Manager 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.

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 17 November 2015.

2.0 Service details

Registered organisation/registered person: Runwood Homes Ltd/ Mr Nadarajah (Logan) Logeswaran	**Registered manager:** Mrs Joanne Neville
Person in charge of the home at the time of inspection: Mrs Joanne Neville	**Date manager registered:** 17 December 2014
Categories of care: RC-I, RC-DE, NH-I, NH-PH, NH-PH(E)	**Number of registered places:** 90

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 two residents, the registered manager, the deputy manager, two registered nurses and one care team leader.

The following records were 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 17 November 2015

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

4.2 Review of requirements and recommendations from the last medicines management inspection dated 28 May 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	It is recommended that eye-treatment medicines should not be used beyond their recommended disposal date.	**Met**
	Action taken as confirmed during the inspection: Dates of opening were recorded on eye-treatment medicine containers. The medicines were in date.	

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 for registered nurses and for care staff who had been delegated medicine related tasks. Refresher training in medicines management was provided annually. Staff had also received refresher training in the use of syringe drivers and pain management. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed 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 patients' admissions to 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.

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. 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, the parameters for administration were recorded on the personal medication record. A care plan was maintained. The reason for and the outcome of administration were not always recorded; a recommendation was made. 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 patient had the thickening agent recorded on their personal medication record and the entry included details of the fluid consistency. Administrations were generally recorded and a care plan and 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.

The registered manager advised that a trust pharmacist had recently reviewed all patients' medicines and made recommendations to the prescribers. This good practice was acknowledged.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included entries on the personal medication records and medicine administration records being signed and verified by two staff and additional records for antibiotic courses, insulin, opioid transdermal patches and warfarin.

Practices for the management of medicines were audited throughout the month by the registered manager and staff. This included running stock balances of many medicines not included in the monitored dosage system blister packs. In addition, a quarterly audit was completed by the community pharmacist. 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 staff, it was evident that, when applicable, healthcare professionals were contacted in response to medicine related concerns or queries. The care files examined contained details of visits by other health care professionals involved in the patient's care and the outcome of each visit.

Areas for improvement

The reason for and the outcome of administration of medicines prescribed for administration on a "when required" basis for the management of distressed reactions should be routinely recorded; a recommendation was made.

Number of requirements:	0	Number of recommendations:	1

4.5 Is care compassionate?

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

Patients advised that they wished the staff to administer their medication and that they had no issues with their management.

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 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.

A review of the audit records indicated that satisfactory outcomes had been achieved.

Following discussion with the registered manager and 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.

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

The issue identified during this inspection is detailed in the QIP. Details of this QIP were discussed with Mrs Joanne Neville, 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 the RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

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

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to 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 by the registered manager. Once fully completed, the QIP will be returned to 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 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.

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 20 May 2016	The registered person should ensure that the reason for and the outcome of administration of medicines prescribed for administration on a "when required" basis for the management of distressed reactions are routinely recorded.
	Response by registered person detailing the actions taken: All relevant staff have been informed that the reason for and the outcome of administration of medicines prescribed for administration on a "when required" basis for the management of distressed reactions are routinely recorded. A record sheet is maintained in each residents administration records to capture this information and this information will also be recorded in the residents progress reports. This recommendation is in our new 'management of distressed reactions and medications' procedure.

authorised email address*

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