Unannounced Medicines Management Inspection Report
4 January 2017

Oakridge Care Home

Type of Service: Nursing Home
Address: 14 Magheraknock Road, Ballynahinch, BT24 8TJ
Tel no: 02897565322
Inspector: Frances Gault

1.0 Summary

An unannounced inspection of Oakridge Care Home took place on 4 January 2017 from 10:00 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.

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 were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. There were no areas of improvement identified.

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. Two areas of improvement were identified in relation to record keeping and the management of thickening agents and two 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. There were no areas of improvement identified

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 usually 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. The good practice of sharing learning across the organisation was evidenced. There were no areas of improvement identified.

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. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

1.1 Inspection outcome

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Kelly Kilpatrick, 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 QIP there were no further actions required to be taken following the most recent inspection on 16 June 2016.

2.0 Service details

Registered organisation/registered person: Spa Nursing Homes Ltd Mr Christopher Philip Arnold	**Registered manager:** Ms Kelly Kilpatrick
Person in charge of the home at the time of inspection: Ms Kelly Kilpatrick	**Date manager registered:** 24 June 2016
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI, NH-DE A maximum of forty (40) patients in the EMI Unit. A maximum of eighteen (18) patients in the General Nursing Unit.	**Number of registered places:** 58

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, one 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.

Twenty-eight questionnaires were issued to staff, patients, relatives/ patients' representatives with a request that these were completed and returned within one week of the inspection.

A sample of 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 16 June 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 inspections on 30 September 2013 and 7 November 2013

Since the last medicines management inspections in 2013, the two previously registered nursing units have been amalgamated and Oakridge Care Home is now registered under Spa Nursing Homes Ltd.

Review of requirements and recommendations from the medicines management inspection of the EMI Unit on 30 September 2013.

There were no requirements of recommendations made as a result of the last medicines management inspection.

Review of requirements and recommendations from the medicines management inspection of the General Nursing Unit on 7 November 2013.

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	A record of the administration of thickening agents must be maintained. **Action taken as confirmed during the inspection**: There was evidence that this is now the practice of the registered nurses and the care staff on the general nursing floor. As written this requirement was met.	**Met**
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must closely monitor the administrations of three medicines. **Action taken as confirmed during the inspection**: The audits undertaken throughout the home produced largely satisfactory results. The samples included two of the three medicines detailed in the previous report. The third medicine was an antibiotic and the audits indicated that antibiotics were being administered as prescribed.	**Met**
Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must ensure all medicines are securely stored. **Action taken as confirmed during the inspection**: All medicines were evidenced to be stored securely.	**Met**
Requirement 4 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must ensure the temperature range of the medicines refrigerator is monitored and recorded each day. **Action taken as confirmed during the inspection**: The records showed that the medicine refrigerators temperatures were being monitored and recorded each day.	**Met**

Last medicines management inspection recommendation		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered person should ensure that discontinued and out-of-date medicines are promptly disposed of.	**Met**
	Action taken as confirmed during the inspection: The evidence seen indicated that medicines were being disposed of in a timely manner.	

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 annually. Refresher training in medicines management, including the use of thickening agents was provided in the last year. The most recent training was in relation to syringe drivers.

Two of the registered nurses on duty were from a nursing agency. Both spoke positively of the systems in place for their orientation within the home and the level of information received on handover.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. A detailed schedule is in place for the acquisition of repeat prescriptions.

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. Staff were reminded of the need to ensure the balance in the book is returned to zero when medicines are disposed of or transferred out of the home. 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. insulin. The use of separate administration charts was acknowledged.

There was evidence in a care plan of the arrangements in place if it was assessed that medicines required to be administered covertly, including discussion with the prescriber and next of kin.

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 majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. However, some discrepancies were observed which were discussed with the registered manager who agreed to include them in the audit sample. It was noted that the prescriber had recently stopped one antibiotic while a patient was receiving another one. However this change was not observed by all staff. It was noted that both had still been documented on the personal medication record. This was discussed with the nurse on duty and the manager who agreed to address the matter.

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, specific 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. Those medicines sampled had not been required to be administered recently. 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 any pain, and a pain tool was used as needed. A care plan was maintained.

The management of swallowing difficulty was examined. Staff spoken to during the inspection were knowledgeable about the management of thickening agents and of the required consistency for each patient. For those patients prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Registered nurses recorded their administration on the medicine administration records. Care staff on the general nursing floor recorded any administration on the fluid charts (see section 4.2) but this practice was not consistent throughout the home. The monitoring of the delegation of this task to care staff was discussed with the registered nurses and manager. A recommendation was made.

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. This was also evidenced in the care records.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate recording sheets for the administration

of antibiotics and controlled drugs and the use of reminder labels when patients shared a surname.

It was noted that the medicine administration times printed on the personal medication records did not correspond with those printed on the medicine administration records. This was discussed with the registered manager and is of particular importance when the medicine round is extended for any reason to ensure that there is an appropriate dosage interval between medicine rounds. On the day of the inspection the round was longer due to the use of agency staff who were less familiar with the patients (see section 4.5). A recommendation was made in relation to the records.

Practices for the management of medicines were audited throughout the month by the staff and management. There was evidence of the registered manager's monitoring of the staff audits.

During the inspection the registered nurses were in contact with general practitioners and other health professionals in relation to the health needs of the patients.

Areas for improvement

Robust systems should be in place for the management of thickening agents. A recommendation was made.

The format of the personal medication record and the medicine administration record should be reviewed to ensure that there is correlation between them. A recommendation was made.

Number of requirements	0	**Number of recommendations**	2

4.5 Is care compassionate?

One of the agency nurses was working their first shift in the home. Time was being taken to administer the medicines. A discussion took place with the nurse regarding the time documented for the administration of medicines to ensure that it was accurate and of the importance of ensuring that an appropriate dosage interval was left before the next medicine round took place (see also section 4.4).

Staff were seen and heard treating patients with respect. Throughout the morning various staff were heard giving assurance to a patient who was anxious about the health of a relative who was currently in hospital.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Twenty eight questionnaires were left in the home to facilitate feedback from patients, staff and relatives. None were returned in time for any comments to be included in the report. Two were returned within the time frame from patients who advised that they were satisfied/very satisfied with all aspects of their care in relation to the management of medicines.

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. The registered manager advised that these were currently being reviewed by the Company.

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. There was also evidence of the learning across the organisation. The regional manager had circulated an email as the result of an inspection elsewhere in the organisation which highlighted the focus and outcome of the inspection. This good practice was acknowledged.

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.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Kelly Kilpatrick, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 the nursing home. 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider 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 Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment 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 provider 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 provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 3 February 2017	The registered provider should ensure robust systems are in place for the management of thickening agents. **Response by registered provider detailing the actions taken:** Management and recording of thickening agents has been reviewed and a robust recording system has been implemented for administration. This will be monitored by the Manager.
Recommendation 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 28 February 2017	The registered provider review the format of the personal medication record and the medicine administration record to ensure that there is correlation between them. **Response by registered provider detailing the actions taken:** The format of personal medication records and medicine administration records have been reviewed to ensure correlation between both. Our printers have also been informed of new changes for future ordering.

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