Unannounced Medicines Management Inspection Report
13 September 2016

Pond Park Care Home

Type of Service: Nursing Home
Address: 2 Derriaghy Road, Lisburn, BT28 3SF
Tel no: 028 9267 2911
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Pond Park Care Home took place on 13 September 2016 from 10.05 to15.30.

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 most areas of the management of medicines supported the delivery of safe care and positive outcomes for patients. There were arrangements for staff training and assessment of competency. Medicines were stored safely and securely. One area in relation to the management of medicine changes was identified for improvement. One requirement has been made.

Is care effective?

Areas for improvement were identified and must be addressed to ensure that the management of medicines in this home supports the delivery of effective care. Whilst there was evidence that medicines supplied in the 28 day blister packs had been administered as prescribed, some medicines had not be administered as prescribed and records had not been fully and accurately maintained. Where the administration of medicines was delegated to care staff for administration, a number of records of administration were incomplete. Improvement is necessary regarding the care planning and record keeping relating to the management of distressed reactions. Three requirements and one recommendation have been 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 spoken to was complimentary about their care in the home and the management of their medicines. No requirements or recommendations have been made.

Is the service well led?

Some areas of the service were found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place to support the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents. Areas for improvement in relation to governance and staff roles and responsibilities were identified. One requirement and one recommendation 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. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	5	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with the Registered Manager, Mrs Suzanne Scott, 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 finance inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 26 July 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons (Bamford) Ltd/ Dr Maureen Claire Royston	**Registered manager:** Mrs Suzanne Scott
Person in charge of the home at the time of inspection: Mrs Suzanne Scott	**Date manager registered:** 19 May 2014
Categories of care: RC-I, NH-I, NH-PH, NH-PH(E), NH-TI, NH-DE	**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.

The inspector met with one resident, one member 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 26 July 2016

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was returned and approved by the finance inspector. This QIP will be validated by the finance inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection 20 August 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered person is required to closely monitor the administrations of warfarin and nebivolol, both prescribed for one patient in Pond Park House, in order to ensure compliance with the prescriber's instructions.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that close monitoring of these medicines had been undertaken at that time. No further discrepancies were observed in warfarin at the inspection. Nebivolol was not currently prescribed.	

Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	Running stock balances of warfarin preparations must be accurately maintained.	**Met**
	Action taken as confirmed during the inspection: A separate administration record was in place for warfarin; this included a daily stock balance.	
Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time	The route of administration of eye-treatment medicines must be routinely recorded on the personal medication record sheets.	**Met**
	Action taken as confirmed during the inspection: Examination of a sample of personal medication records indicated that the route of administration for eye preparations was clearly recorded.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 38 **Stated:** First time	Obsolete personal medication record sheets and warfarin dosage forms should be archived.	**Met**
	Action taken as confirmed during the inspection: There were systems in place to remove obsolete records.	
Recommendation 2 **Ref**: Standard 39 **Stated:** First time	In-use insulin should be stored at room temperature, in accordance with the manufacturers' instructions.	**Met**
	Action taken as confirmed during the inspection: The insulin pen in current use was stored at room temperature.	

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. Competency assessments were completed annually. Refresher training in medicines management was provided in the last year.

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. However, it was noted that one medicine had been out of stock for three days, this had not been reported to the registered manager. The

staff advised that this had been ordered and delivery was expected later today. The registered manager confirmed by email on 14 September 2016 that this medicine was now available.

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.

The management of medicines changes requires review. Although there was evidence that two staff had been involved in writing and updating personal medication records and handwritten medication administration records, to ensure accuracy, it was noted that for three medicines which were prescribed on personal medication records, there was no recent record of administration and there was no supply of the medicine. Staff could not confirm if these medicines were currently prescribed. A requirement was made. The registered manager clarified by email on 14 September 2016 that two of the medicines had been discontinued some time ago and the other medicine should have been administered, but was now discontinued following discussion with the prescriber.

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.

Appropriate arrangements were in place for administering medicines in disguised form.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. Staff were reminded that records of disposal should clearly state that Schedule 4 controlled drugs have been denatured.

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. The oxygen mask and tubing was not protected in one area of the home; the daily audit for this supply of oxygen indicated that this mask and tubing were covered. It was agreed that this would be addressed after the inspection. Staff were reminded that sachets of lidocaine plasters must remain sealed at all times.

Areas for improvement

Robust arrangements for the management of medicine changes must be developed to ensure that the prescribed care and treatment is provided to patients to meet their individual needs. A requirement was made.

Number of requirements	1	**Number of recommendations**	0

4.4 Is care effective?

The majority of medicines which were examined had been administered in accordance with the prescriber's instructions. However, some discrepancies in the audit trails were observed and highlighted to the registered manager at the inspection. A recommendation regarding the auditing process was made in section 4.6.

There was evidence that time critical medicines had been administered at the correct time. There were robust arrangements in place to alert staff of the next date of administration of medicines which were prescribed twice weekly, three times weekly or three monthly. The dates were clearly marked out on the administration records.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were usually recorded on the personal medication record. A care plan was in place for some but not all of the patients prescribed these medicines. 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. It was acknowledged that a separate chart was available to record the reason and outcome of medicines administered on "when required" basis; however, this was not being fully maintained. A recommendation was made.

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. Staff also advised that a pain assessment is completed as part of the admission process.

Some of the medicine records had been maintained in a satisfactory manner. Areas of good practice were noted and included the use of separate administration records for transdermal patches. However, it was noted that improvement was required in the standard of maintenance of the records of prescribing and administration. Several personal medication records were not up to date, some doses and strengths of medicines were missing, there were amended entries and the date of discontinuation of medicines was not always recorded. It was reiterated that these records may be used by other health care professionals and must be fully and accurately maintained at all times. A requirement was made. In relation to administration records, the audit trails attempted on a number of external preparations could not be concluded as a record of the administration was not maintained. For some of these medicines, it could not be ascertained who was responsible for administration and if the medicine had been administered in accordance with the prescribers instructions. A record of all administered medicines must be maintained and a requirement was made.

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. Care plans and speech and language assessment reports were in place. These medicines were administered by the registered nurses and the care staff. However, some records of administration were incomplete. It was reiterated that a record of all administered medicines must be maintained. A system should be in place to ensure that records which are completed by care staff are reviewed within the audit process.

The management of medicines administered via an enteral feeding tube was examined. It was found that further detail must be recorded on the fluid intake chart. These charts should clearly indicate that the administration of medicines is accompanied by flushes of water, the administration of all fluids is accurately recorded and the total intake is recorded every 24 hours; a system should be developed to ensure that the prescribed target fluid intake is achieved. A requirement 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 recorded in patient's care file. However, it was noted that one eye preparation had been refused for several weeks; this had not been reported to the prescriber or the registered manager. This issue was addressed after the inspection.

Areas for improvement

The management of distressed reactions should be reviewed to ensure that this is recorded in a care plan and the reason and outcome of each administration is recorded. A recommendation was made.

Personal medication records must be kept fully and accurately maintained at all times. A requirement was made.

The administration of a medicine or reason for any non-administration must be recorded on every occasion. A requirement was made.

The management of medicines administered via an enteral feeding tube must be reviewed to ensure that the fluid intake chart is fully and accurately maintained. A requirement was made.

Number of requirements	3	**Number of recommendations**	1

4.5 Is care compassionate?

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.

The patient spoken to at the inspection stated that they were content with their care in the home and had no concerns regarding the management of their medicines. They advised that staff responded in a timely manner to any requests for medicines e.g. pain relief. They spoke positively about the staff.

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.

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.

Whilst there was various auditing activity regarding medicines management, an effective auditing process for medicines management was not evidenced at the inspection. Due to the findings of the inspection, as detailed in the report, the current auditing system must be reviewed. A requirement was made. As part of best practice, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

With regard to staff roles and responsibilities for medicines management, this should be reviewed; in particular, the management of external preparations and also regarding information which must be reported to the registered manager e.g. ongoing refusal of medicines, out of stock medicines. A recommendation was made.

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

Areas for improvement

A robust auditing process for medicines management must be developed and implemented. A requirement was made.

Roles and responsibilities in relation to medicines management should be reviewed with staff. A recommendation was made.

Number of requirements	1	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Suzanne Scott, 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 pharmacists@rqia.org.uk 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

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 12(1) **Stated:** First time **To be completed by:** 13 October 2016	The registered provider must make the necessary arrangements to ensure robust arrangements are in place to manage medicine changes.
	Response by registered provider detailing the actions taken: Discussion with the Registered Nurses resulted in the Nurses fully understanding that medication discontinued by the GP must be signed by 2 Registered Nurses and disposed of according to the appropriate policy. Newly prescribed medication must be checked by 2 Registered, tally on both medicine chart and MARR sheet and signed by 2 Registered Nurses.This will be monitored on a weekly basis using the Quality of life audit
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 13 October 2016	The registered manager must ensure that personal medication records are fully and accurately maintained at all times.
	Response by registered provider detailing the actions taken: Daily and weekly audits take place to ensure that the above is adhered to. Medicine Kardex are rewritten on a yearly basis following reviews by the GP's or more often if required.
Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 13 October 2016	The registered provider must ensure that a record of the administration or non-administration of a medicine is maintained on every occasion.
	Response by registered provider detailing the actions taken: Following discussion with the registered nurses it was reiterated that all administration of medicines must be signed for appropriately. All non administration of medicine must be accounted for and coded correctly on the back of the MARR sheet.This will be monitored via the weekly medication audit
Requirement 4 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 13 October 2016	The registered provider must review the management of medicines administered via an enteral feeding tube to ensure that the fluid intake chart is fully and accurately maintained.
	Response by registered provider detailing the actions taken: All medication administered via an enteral feeding tube is entered on the fluid balance chart. All enteral feeds and water administered are fully and accurately maintained on the fluid balance chart. This will be monitored and reviewed by the Home Manager and Deputy Manager during weekly audits

Requirement 5 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 13 October 2016	The registered provider must develop a robust system to audit all aspects of medicines management and ensure that any areas for improvement are followed up. **Response by registered provider detailing the actions taken:** Daily, weekly and monthly audits are carried out for medicine management - and discrepencies or areas for improvement are acted opon in the appropriate manner.
Recommendations	
Recommendation 1 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 13 October 2016	The registered provider should review the management of distressed reactions to ensure that this is recorded in a care plan and the reason and outcome of each administration are recorded on every occasion. **Response by registered provider detailing the actions taken:** The management of distressed reactions regarding administration of medicines has been reviewed - if a distressed reactions occurs and administration of medication is givinen the reason and outcome/effect of the medication will be recorded.
Recommendation 2 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 13 October 2016	The registered provider should make the necessary arrangements to ensure that staff are aware of their roles and responsibilities in relation to medicines management. **Response by registered provider detailing the actions taken:** The roles and responsibilites regarding administration of medicines has been discussed with all Registered Nurses. Nurses have been reissued with the NMC admisnistration of medication guidance anf FSHC policy on adminsitration of medication.

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