Unannounced Medicines Management Inspection Report
2 February 2017

Lecale Lodge

Type of Service: Nursing Home
Address: 26 Strangford Road, Downpatrick, BT30 6SL
Tel no: 028 4461 6487
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Lecale Lodge took place on 2 February 2017 from 10.30 to 15.40.

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. No requirements or recommendations were made.

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. One area of improvement was identified in relation to record keeping and a requirement was 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. Patients consulted with confirmed that they were administered their medicines appropriately. No requirements or recommendations were made.

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 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. 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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Lecale Lodge which provides both nursing and residential care.

1.1 Inspection outcome

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Linda Graham, 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 26 September 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Mrs Linda Graham
Person in charge of the home at the time of inspection: Mrs Linda Graham	**Date manager registered:** 29 January 2014
Categories of care: RC-PH, NH-MP, NH-MP(E), RC-I, NH-TI, NH-PH(E), NH-PH, NH-I	**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.

We met with one patient, three members of the care team, one team leader, two registered nurses and the registered manager.

Fifteen questionnaires were issued to patients, relatives/representatives and staff, with a request that they were returned within one week from the date of the inspection.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- 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 September 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 inspection 9 February 2015

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that the medicines refrigerators are maintained within the required range of 2^{o}C and 8^{o}C and the thermometers are reset daily.	**Met**
	Action taken as confirmed during the inspection: The daily records for refrigerator temperatures indicated that temperatures were being maintained within the recommended range. Registered nurses confirmed that the thermometers were being reset each day after the maximum, minimum and current temperatures were recorded.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 39 **Stated:** First time	The registered manager should review the storage of oxygen.	**Met**
	Action taken as confirmed during the inspection: Oxygen cylinders were observed to be stored securely and masks were covered.	

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 on the management of medicines via the enteral route and syringe drivers had been 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. One inhaled medicine was observed to be out of stock on the day of the inspection; this had been ordered and was followed up during the inspection.

There were satisfactory arrangements in place to manage changes to prescribed medicines. The majority of personal medication records and handwritten entries on the 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. 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.

Mostly satisfactory arrangements were in place for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged. Registered nurses were reminded that obsolete warfarin dosage directions should be cancelled and archived. Dates of opening had not been recorded on two supplies of insulin; it was acknowledged that this was an oversight and that at the prescribed dose the insulin pens would be finished prior to expiry.

Satisfactory arrangements were in place for the management of medicines and nutrition via the enteral route. Detailed feeding regimens were in place. In addition details of how each medicine should be administered were available on the medicines files.

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 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 registered manager advised that the room temperature of each treatment room continues to be closely monitored as temperatures of 24^{o}C and 25^{o}C continue to be recorded. In the Quoile Suite one supply of temazepam tablets were not stored in the controlled drugs cabinet. This was addressed during the inspection. The registered manager advised that a larger controlled drug cabinet would be obtained.

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 medicines examined had been administered in accordance with the prescriber's instructions. One discrepancy in the administration of a liquid medicine was highlighted to the registered manager for investigation and close monitoring. 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 dosage instructions were recorded on the personal medication record. Care plans were in place. 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. It was noted that some patients were prescribed more than one medicine for the management of their distressed reactions. It was agreed that the care plans would be updated to identify which medicine should be used first line.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were maintained. 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 assessment tool was used as needed. Pain assessments were 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 and included details of the fluid consistency. Care plans and speech and language assessment reports were in place. Each administration was recorded.

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 majority of medicines records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. Registered nurses were reminded that the date of writing should be recorded on all personal medication records. Improvements in the standard of maintenance of the medication administration records are necessary. Records for the administration of one thickening agent had been signed prior to the actual administration. For a second patient the records of administration of an inhaled medicine had been completed but the medicine was not available. For a third patient the records of administration of prednisolone did not correlate with the actual dose administered; the correct dose had been administered. The registered provider must ensure that medication administration records are accurately maintained on all occasions. A requirement was made.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several medicines which were not contained within the blister pack system. 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

The registered provider must ensure that medication administration records are accurately maintained on all occasions. A requirement was made.

Number of requirements	1	Number of recommendations	0

4.5 Is care compassionate?

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were observed to respond promptly to patient requests.

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 they were happy with the care provided in the home. They confirmed that staff were attentive and responded to their needs quickly.

As part of the inspection process 15 questionnaires were issued to patients, relatives/ representatives and staff, with a request that they were returned within one week from the date of the inspection. Four patients, one relative and two members of staff returned the questionnaires. The responses were positive and these were recorded as "satisfied" or "very satisfied" with regard to the management of medicines in the home.

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 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.

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

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 Mrs Linda Graham, 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 the 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.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 3 March 2017	The registered provider must ensure that medication administration records are accurately maintained on all occasions.
	Response by registered provider detailing the actions taken: The Registered Manager has increased auditing of the medication kardex against mars sheet to ensure the records are accurately maintained.

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.

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