Unannounced Medicines Management Inspection Report
9 March 2017

Wood Lodge

Type of Service: Nursing Home
Address: Mill Hill, Castlewellan, BT31 9NB
Tel no: 028 4377 8511
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Wood Lodge took place on 9 March 2017 from 09:35 to 13:45.

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. It was evident that the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. 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. There were no areas of improvement identified.

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. 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 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. 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 prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008. Please refer to section 4.2 of this report.

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

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 Mrs Elizabeth O'Rourke, 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 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 31 May 2016.

2.0 Service details

Registered organisation/registered person: G & M Lodge Care Ltd Mr Liam John Lavery	**Registered manager:** Mrs Elizabeth O'Rourke
Person in charge of the home at the time of inspection: Mrs Elizabeth O'Rourke	**Date manager registered:** 31 March 2014
Categories of care: RC-I, RC-PH, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 49

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 five patients, the registered manager, two registered nurses and one senior care assistant.

Twenty-five questionnaires were issued to patients, patients' representatives and staff with a request that they were returned within one week from the date of this inspection.

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.

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
- care plans
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 31 May 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 3 February 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** Second time	The responsible person must ensure that robust systems are in place for the management of medicines for patients admitted or readmitted to the home. Records must facilitate a clear audit trail.	**Met**
	Action taken as confirmed during the inspection: Robust systems were in place for the management of medicines for patients admitted or readmitted to the home. For the two most recent admissions, there was correlation between the hospital discharge letters, personal medication records and medicine administration records. Two registered nurses had initialled handwritten entries on the personal medication records and medicine administration records.	

Requirement 2 **Ref:** Regulation 13(4) **Stated:** Second time	The responsible person must review and revise the systems in place for the management of nutritional supplements. Records must facilitate a clear audit trail.	**Met**
	Action taken as confirmed during the inspection: The systems for the management of nutritional supplements had been reviewed and revised. Key workers audit their patients' supplements which, in turn, are audited by the registered manager. An additional recording sheet had been introduced for the recording of nutritional supplements. Two audits performed on nutritional supplements, as part of the inspection process, produced satisfactory outcomes.	
Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that two members of staff verify and sign the personal medication records when they are written and updated.	**Met**
	Action taken as confirmed during the inspection: Handwritten entries on personal medication records were initialled by two members of staff.	
Requirement 4 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that two members of staff verify and sign all handwritten entries on the medication administration records.	**Met**
	Action taken as confirmed during the inspection: Handwritten entries on the medication administration records were initialled by two members of staff.	
Requirement 5 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that controlled drugs in Schedules 2, 3 and 4 (Part 1) are denatures prior to their disposal.	**Met**
	Action taken as confirmed during the inspection: From discussion with staff and examination of the disposal of medicines record, it was evident that controlled drugs in Schedules 2, 3 and 4 (Part 1) were denatured prior to their disposal.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** Second time	The responsible person should ensure that the management of when required medicines for the management of distressed reactions is reviewed and revised as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The management of when required medicines for the management of distressed reactions had been reviewed and revised. Care plans were maintained. The reason for and the outcome of administration were recorded.	

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 was provided in the last three years.

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 medicine administration records were updated by two staff members. 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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. Whilst the controlled drugs disposal record had been initialled by two staff members, this practice had not always been the case for non-controlled drugs. The registered manager gave an assurance that this matter would be rectified without delay.

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 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 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. 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. A pain assessment 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.

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. Administrations were recorded and care plans and speech and language assessment reports 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.

Medicine records were well maintained and facilitated the audit process.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for analgesics and some inhaled medicines. In addition, a periodic 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 patients' needs.

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?

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. Patients advised that they were very satisfied with the care experienced.

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.

As part of the inspection process, we issued questionnaires to patients, patients' representatives and staff. No questionnaires were returned within the specified timeframe.

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.

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 usually 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.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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