Unannounced Medicines Management Inspection Report
20 September 2016

Castlehill

Type of Service: Nursing Home
Address: 14 Bellshill Road, Castledawson, BT45 8HG
Tel no: 028 7946 8730
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Castlehill took place on 20 September 2016 from 10.05 to 13.55.

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 working relationship with the community pharmacist, 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. 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 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	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Ms Bernadette O'Neill, 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 6 June 2016.

2.0 Service details

Registered organisation/registered person: Safecare Chrysalis Ltd Mr Brian J McAteer Mr Cathal McAteer	**Registered manager:** Ms Bernadette O'Neill
Person in charge of the home at the time of inspection: Ms Bernadette O'Neill	**Date manager registered:** 27 January 2011
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 34

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 two patients, one registered nurse 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 6 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 inspection dated 2 September 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that Schedule 4 (Part1) controlled drugs are denatured prior to disposal.	**Partially Met**
	Action taken as confirmed during the inspection: The majority of these medicines had been denatured prior to disposal. Records were maintained. A couple of examples of these medicines being disposed of without being recorded as having been denatured were observed in recent weeks, this was discussed and the registered manager took immediate action to address this and remind staff of the correct procedures for recording their destruction. For this reason this requirement was not restated.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should ensure that standard operating procedures for controlled drugs are reviewed and revised to include updated procedures for the management and disposal of controlled drugs.	**Met**
	Action taken as confirmed during the inspection: Standard operating procedures for controlled drugs had been reviewed and revised following the last inspection and reviewed again in July 2016. There was evidence that these procedures had been shared with staff.	
Recommendation 2 **Ref**: Standard 38 **Stated:** First time	The registered manager should ensure that the method of recording the time of administration of bisphosphonate medicines is reviewed.	**Met**
	Action taken as confirmed during the inspection: The method of recording the time of administration was reviewed following the last inspection and this was evidenced in medicine administration records. Staff were aware of the administration requirements for these medicines.	

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 June 2015. Staff had also received training in the management of epilepsy and in enteral feeding and the administration of medicines via this route.

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 were mostly updated by two designated members of staff. Staff were reminded that entries should be verified on every occasion.

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. The controlled drugs prescribed for use at the time of the inspection were not subject to record keeping requirements.

A small number of medicines were crushed prior to administration. These medicines were administered via an enteral tube. Written authorisation from the prescriber was in place.

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

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were mostly denatured and rendered irretrievable prior to disposal (see section 4.2).

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised in the limited space available. A second trolley is now in use to provide extra space. 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?

Most of the medicines examined had been administered in accordance with the prescriber's instructions. A small number of inhaled medicines did not state the date of opening and the audit trails could not be concluded. Staff were reminded to record the date of opening on all medicines to facilitate audit.

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. 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. These medicines had not been used recently, however staff confirmed that the reason for and the outcome of administration were recorded. A care plan was maintained, the development of care plans was discussed and it was advised that details of patient specific behaviour should be included. The registered manager addressed this immediately.

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 pain was well controlled and the patient was comfortable. Staff advised that most of the patients could verbalise any pain and that staff can otherwise recognise patient specific behaviour. It was discussed and agreed that this detail should be included in the care plan. The registered manager addressed this immediately.

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.

The management of enteral feeding was examined. Fluid intake charts were maintained and included the total volume of fluid intake per 24 hours where recommended by the prescribing professional.

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 generally well maintained and facilitated the audit process. The registered manager was in the process of rewriting some personal medication records which were becoming full. Staff were reminded to record the date of writing on personal medication records on every occasion.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to issues or concerns relating to medicines management.

Practices for the management of medicines were audited throughout the month by the staff and management. Records indicated that good outcomes had been achieved.

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.

It was not possible to ascertain the views and opinions of patients specifically regarding their medicines but those spoken to were content and happy to chat. Patients were relaxed and comfortable in their surroundings and in their interactions with staff, which were observed to be kind, caring and cheerful.

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 internal 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 and the registered nurse, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

The requirement and recommendations made at the last medicines management inspection had been satisfactorily addressed.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated to staff individually and at 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

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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