Unannounced Medicines Management Inspection Report
5 September 2016

Clonlee

Type of Service: Nursing Home
Address: 132 Belfast Road, Muckamore, Antrim, BT41 2ET
Tel No: 028 9446 1166
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Clonlee took place on 5 September 2016 from 10.15 to 14.40.

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 some areas for the management of medicines supported the delivery of safe care and positive outcomes for patients. However, improvements in the management of the cold storage of medicines, the recording systems for insulin and medicines administered via the enteral route, reviewing staff competencies and recording dates of opening on all medicines were necessary. One requirement and four recommendations were made. One of these recommendations was stated for the second time.

Is care effective?

Some areas for the management of medicines supported the delivery of effective care. However, accurate records for the administration of thickening agents must be maintained. Care plans for the management of pain should be in place for all patients who are prescribed regular analgesia. A robust audit tool should be implemented. One requirement and two recommendations were made. One of these recommendations was stated for the second time.

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 for improvement identified during the inspection.

Is the service well led?

Improvements were necessary in this domain with respect to the management of medicines. There were poor systems in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. The governance arrangements were not robust. Two of the recommendations which were made at the last medicines management inspection had not been addressed. In addition to the requirements and recommendations made in the other domains a further recommendation with regard to regularly reviewing the Quality Improvement Plan was 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.

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

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	7

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Perpetua Latta, 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 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 20 July 2016.

2.0 Service details

Registered organisation/registered person: Hutchinson Homes Ltd Mrs Janet Montgomery Ms Naomi Carey	**Registered manager:** Mrs Perpetua Latta
Person in charge of the home at the time of inspection: Mrs Perpetua Latta	**Date manager registered:** 1 April 2005
Categories of care: NH-I, NH-LD, RC-PH(E), NH-PH	**Number of registered places:** 53

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; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with one patient, one care assistant, three registered nurses and the registered manager.

As 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 20 July 2016.

The most recent inspection of the home was an announced 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 on 25 June 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 28 **Stated:** First time	It is recommended that the date of opening is recorded for all medicines to facilitate the audit process.	**Not Met**
	Action taken as confirmed during the inspection: The date of opening had not been recorded on the majority of medicines. This meant that several audits could not be completed and there was a risk that medicines could remain in use after their expiry date had been reached. This recommendation was stated for the second time.	
Recommendation 2 **Ref:** Standard 29 **Stated:** First time	It is recommended that the management of medicines prescribed on a “when required” basis for distressed reactions is reviewed and revised.	**Met**
	Action taken as confirmed during the inspection: The records for two patients were reviewed. Care plans were in place for both patients. The reason for and outcome of each administration had been recorded.	

Recommendation 3 **Ref:** Standard 29 **Stated:** First time	It is recommended that the management of medicines prescribed for the management of pain is reviewed and revised.	**Not Met**
	Action taken as confirmed during the inspection: This recommendation referred to care plans for the management of pain for patients who were prescribed regular analgesia. Care plans were not in place for three of the four records reviewed. This recommendation was stated for the second time.	

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 registered manager advised that update training in the management of medicines had been provided by the community pharmacist approximately two years ago. Competency assessments were completed by the community pharmacist following this training. The registered manager advised that further competency assessments would be completed only if a need was identified. The registered manager should complete competency assessments with all registered nurses and care assistants annually. A recommendation was made. Refresher training on the management of Parkinson's, epilepsy, syringe drivers and the administration or management of medicines via the enteral route had been provided within 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.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two registered nurses. This safe practice was acknowledged. The registered manager and registered nurses were reminded that obsolete personal medication records should be cancelled and archived.

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 controlled drug record books. 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 observed for the management of warfarin; dosage directions were received in writing, transcribing involved two staff, separate administration charts were used and daily stock counts were maintained. The registered manager and registered nurses were reminded that obsolete dosage directions should be cancelled and archived.

The management of insulin was reviewed. As detailed in Section 4.2 dates of opening had not been recorded on insulin pens. This does not facilitate a clear audit trail or disposal at expiry. In addition the dosage directions had been abbreviated on the records for one patient; it was acknowledged that this was an oversight and that it would be highlighted to all registered nurses. Records of blood glucose levels and administration were maintained on medication administration records. In the interests of safe practice separate recording sheets should be used to record blood glucose levels and the dose of insulin administered. A recommendation was made.

A number of patients have their medicines administered via the enteral route. This was clearly recorded on the personal medication records and detailed guidance on how to administer nutrition, fluids and medicines via this route was provided by the Trust for each patient. The registered manager confirmed that registered nurses were trained and competent to administer medicines via the enteral route. Records of administration of medicines, nutrition and water were maintained on the medication administration records. In the interests of safe practice daily fluid intake charts should be maintained to evidence that the recommended fluid intake has been administered each day. A recommendation was made.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

The majority of medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Oxygen was stored securely and appropriate signage was in place. A number of spacer devices needed to be cleaned or replaced. The registered manager advised that this would be done before the end of the day. As stated in Section 4.2, dates of opening had not been recorded on several medicines and hence there was a risk that medicines could remain in use after their expiry date. A recommendation has been stated for the second time.

The management of the cold storage of medicines requires review; temperature recordings outside of the accepted range (2^{o}C to 8^{o}C) were observed on several days and no corrective action had been taken. This had been highlighted at the last medicines management inspection but had not been addressed. A requirement was made.

Areas for improvement

The registered providers must ensure that medicines which require cold storage are stored at the correct temperature. Corrective action must be taken when temperatures outside the accepted range are observed. A requirement was made.

The date of opening should be recorded for all medicines to facilitate the audit process. A recommendation was stated for the second time.

The registered manager should complete competency assessments with all trained staff at regular intervals. A recommendation was made.

The registered manager should ensure that a separate recording sheet is used to record blood glucose levels and the dose of insulin administered. A recommendation was made.

In the interests of safe practice, daily fluid intake charts should be maintained for patients who have their medicines administered via the enteral route to evidence that the recommended fluid intake has been administered each day. A recommendation was made.

Number of requirements	1	**Number of recommendations**	4

4.4 Is care effective?

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.

Four records for the management of pain were reviewed for patients who required regular analgesia. The medication administration records indicated that the medicines had been administered as prescribed. However for three of these patients, care plans which referenced their pain management were not in place. The recommendation which was made at the last medicines management inspection was stated for a second time. 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. The registered manager 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. Care plans and speech and language assessment reports were in place. Registered nurses recorded each administration on the medication administration records. Records of administration by care assistants were not being maintained. The registered manager must ensure that care staff record the administration of thickening agents. 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.

Medicine records were well maintained and facilitated the audit process. As stated in Section 4.3 the registered manager agreed to ensure that obsolete records would be cancelled and archived. Registered nurses were reminded that the date on which medicines are received into the home must be recorded on all occasions.

The registered manager advised that the community pharmacist audits the management of medicines regularly. A review of the most recent audit indicated that an action plan had been provided and the issues identified were being addressed. A small number of audit trails were also completed by registered nurses. However these audits were not effective, as they were incomplete and had not identified any of the issues highlighted at this inspection. The registered manager should implement a robust audit tool. A recommendation was made.

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 providers must ensure that care staff record the administration of thickening agents. A requirement was made.

The management of medicines prescribed for the management of pain should be reviewed and revised. A recommendation was made for the second time.

The registered providers should implement a robust audit tool to provide evidence that medicines are being administered as prescribed. A recommendation was made.

Number of requirements	1	**Number of recommendations**	2

4.5 Is care compassionate?

Appropriate arrangements were in place to facilitate patients responsible for the self-administration of medicines.

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 how their medicines were managed. The patient confirmed that they could request additional pain relief when necessary.

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. Management advised that these were reviewed regularly. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

The registered manager and one of the registered nurses advised that there were robust arrangements in place for the management of medicine related incidents. No medication related incidents had been reported since the last medicines management inspection. As stated in Section 4.4 the home's auditing system was not robust and hence medication related incidents may not be identified. This was discussed with the registered manager.

This inspection took place on day one of the medicines cycle; the sample of medicines which had been opened on the morning of the inspection had been administered as prescribed. However, several audits on other medicines could not be completed as dates of opening had not been recorded. This is unsatisfactory. The registered manager must be able to evidence that medicines have been administered as prescribed. A recommendation regarding the home's auditing system was made in Section 4.4.

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.

Two of the three recommendations made at the last medicines management inspection had not been addressed effectively. To ensure that these are fully addressed and the improvement sustained, it was recommended that the QIP should be regularly reviewed as part of the quality improvement process.

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 at team meetings.

Areas for improvement

The Quality Improvement Plan should be regularly reviewed as part of the quality improvement process. A recommendation was made.

Number of requirements	0	**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 Perpetua Latta, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered providers/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 providers 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 service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 5 September 2016	The registered providers must ensure that medicines which require cold storage are stored at the correct temperature. Corrective action must be taken when temperatures outside the accepted range are observed.
	Response by registered provider detailing the actions taken: On investigation it was noted that the probe was situated in the wrong area of the fridge and from repositioning all fridge temperatures have been in range.
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 5 September 2016	The registered providers must ensure that care staff record the administration of thickening agents.
	Response by registered provider detailing the actions taken: Records have updated to included the administration of thickening agents
Recommendations	
Recommendation 1 **Ref:** Standard 28 **Stated:** Second time **To be completed by:** 5 September 2016	It is recommended that the date of opening is recorded for all medicines to facilitate the audit process.
	Response by registered provider detailing the actions taken: Steps taken to immediately to facilate audits
Recommendation 2 **Ref:** Standard 29 **Stated:** Second time **To be completed by:** 5 September 2016	It is recommended that the management of medicines prescribed for the management of pain is reviewed and revised.
	Response by registered provider detailing the actions taken: Discussed with staff and careplans updated to include pain management

Recommendation 3 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 5 September 2016	The registered providers should ensure that competency assessments on the management of medicines are completed with all trained staff at regular intervals.
	Response by registered provider detailing the actions taken: Competency assessments completed at induction period with all staff nurses.
Recommendation 4 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 5 September 2016	The registered providers should ensure that a separate recording sheet is used to record blood glucose levels and the dose of insulin administered.
	Response by registered provider detailing the actions taken: Blod glucose recorded in individual booklets and insulin administered is recorded on separated sheets and countersigned
Recommendation 5 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 5 September 2016	The registered providers should ensure that accurate daily fluid intake charts are maintained for all patients who receive fluids, nutrition and medicines via the enteral route.
	Response by registered provider detailing the actions taken: Discussed with staff and will continue to monitor fluids via kardex
Recommendation 6 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 5 September 2016	The registered providers should implement a robust audit tool to provide evidence that medicines are being administered as prescribed.
	Response by registered provider detailing the actions taken: The dating of the opening of medication will assist in the auditing of administered medication
Recommendation 7 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 5 September 2016	The registered providers should ensure that this Quality Improvement Plan is regularly reviewed as part of the quality improvement process.
	Response by registered provider detailing the actions taken: Quality Improvement plan will be reviewed quarterly

The Regulation and Quality Improvement Authority

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