Unannounced Medicines Management Inspection Report
1 December 2016

Kingscourt

Type of Service: Nursing Home
Address: 928 Antrim Road, Templepatrick, BT39 0AT
Tel no: 028 9443 2046
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Kingscourt took place on 1 December 2016 from 11.00 to 14.10.

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. Two areas of improvement were identified in relation to record keeping and facilitating audit and two recommendations were 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 were complementary about their care. 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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Liam Dowd, Registered Nurse, 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 28 April 2016.

2.0 Service details

Registered organisation/registered person: Manor Healthcare Ltd Mr Eoghain King	**Registered manager:** Mr Brian Campbell
Person in charge of the home at the time of inspection: Mr Brian Campbell	**Date manager registered:** 1 April 2005
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 19

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, 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.

Twenty-five questionnaires were issued to patients, patients' relatives/representatives and staff, with a request that these were completed and returned to RQIA within one week of 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 28 April 2016

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

4.2 Review of recommendations from the last medicines management inspection dated 7 October 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 38 **Stated:** Second time	The registered manager should ensure that entries in the controlled drug record book are checked on each occasion when stock reconciliation and the transfer of responsibility for safe custody of controlled drugs take place.	**Met**
	Action taken as confirmed during the inspection: There was evidence that procedures had been reviewed and that this now takes place at each transfer of responsibility.	
Recommendation 2 **Ref**: Standard 29 **Stated:** First time	It is recommended that the registered manager should review the administration of external preparations by designated care assistants to ensure that records of administration are accurately maintained and monitored regularly.	**Met**
	Action taken as confirmed during the inspection: There was evidence that procedures had been reviewed. A separate administration record was in place for external medicines administered by designated care assistants. The examples examined had been maintained satisfactorily. The completion of these records was overseen by the registered nurses.	

Recommendation 3 **Ref**: Standard 18 **Stated:** First time	It is recommended that the registered manager should monitor the completion of records regarding the management of distressed reactions, to ensure that the prescribed medication is detailed in the care plan and that the reason for and outcome of administration is recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: There was evidence that procedures had been reviewed. A small number of examples of administration were examined as these medicines were used infrequently. Care plans were in place and the reason for and outcome of each administration had been recorded.	

4.3 Is care safe?

Medicines were managed by staff that had 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.

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.

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. insulin. 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.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and 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. It was

discussed and agreed that the medicine refrigerator thermometer would be reset after recording temperatures on every occasion.

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 that could be audited had been administered in accordance with the prescriber's instructions. Some audits could not be completed as dates of opening had not been recorded. 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. The reason for and 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. Staff advised that most of the patients could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment was 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. The prescribed consistency recorded did not always correlate with the care plans and speech and language assessment reports in place. However, staff confirmed that the patients had received the prescribed consistency in accordance with the most recent speech and language assessment report. A recommendation was made regarding record maintenance.

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 when the date of opening was recorded on medicines. However, a number of medicines examined were not marked with the date of opening and therefore an audit trail could not be completed. A recommendation was made.

Practices for the management of medicines were audited throughout the month by the staff and management. This included maintaining running stock balances for several medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff and a review of the care files, it was evident that when applicable, other healthcare professionals were contacted in response to concerns about medicines management.

Areas for improvement

Records should be reviewed to ensure that the prescribed consistency of thickened fluid recorded on the personal medication record and care plan, correlate with the most recent speech and language assessment. A recommendation was made.

The date of opening should be recorded on all medicines to facilitate audit. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

The administration of medicines to patients was completed in a caring manner, patients were given time and encouragement to take their medicines and medicines were administered as discreetly as possible. Medicines were dispensed from their container, immediately prior to administration.

The patients spoken to were complimentary about their care in the home and about the staff. There was evidence of good relationships between patients and staff/visitors.

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, questionnaires were issued to patients, relatives/patients' representatives and staff. Seven service users completed and returned these within the specified timescale. All of the responses were recorded as either 'satisfied' or 'very satisfied' with the medicines management in the home. One service user was satisfied the medicines management in the home but expressed concerns about the level of noise in the home at times. Management were aware of the patient's concern and agreed to take the necessary steps to address it.

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 arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. The medicine related incident

reported since the last medicines management inspection was discussed. There was evidence of the action taken and learning implemented following incidents. Staff confirmed that they had been made aware of medicine related 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 and 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.

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

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 Mr Liam Dowd, Registered Nurse, 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 the web portal 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	
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 31 December 2016	The registered provider should review records to ensure that the prescribed consistency of thickened fluid recorded on the personal medication record and care plan, correlate with the most recent speech and language assessment.
	Response by registered provider detailing the actions taken: The named nurse responsible for each patient shall review records to ensure that the prescribed consistency of thickened fluid recorded on the personal medication record and care plan, correlates with the most recent speech and language assessment. This shall be completed within the time scale prescribed.
Recommendation 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 31 December 2016	The registered provider should ensure that the date of opening is recorded on all medicines to facilitate audit.
	Response by registered provider detailing the actions taken: Nurses will receive additional supervision to highlight the requirement for the date of opening to be recorded on all medicines opened to facilitate audit.

Please ensure this document is completed in full and returned to the web portal

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