The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report
13 June 2016

Castleview

Type of Service: Nursing Home
Address: 40-42 Scotch Quarter, Carrickfergus, BT38 7DP
Tel No: 028 9336 6763
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Castleview took place on 13 June 2016 from 10:20 to 14:35.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

Is care safe?
No requirements or recommendations have been made.

Is care effective?
One recommendation in relation to records for the management of distressed reactions has been stated for a second time; two recommendations regarding records for pain management and controlled drugs have been made. No requirements have been made.

Is care compassionate?
No requirements or recommendations have been made.

Is the service well led?
No requirements or recommendations have been 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. 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**	**3**

Details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager, Miss Rhonda Murray, 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

There were no further actions required to be taken following the most recent inspection on 18 April 2016.

2.0 Service details

Registered organisation/registered provider: Castleview Private Nursing Home Ltd / Mrs Lynda McCourt	**Registered manager:** Miss Rhonda Murray
Person in charge of the home at the time of inspection: Miss Rhonda Murray	**Date manager registered:** 19 August 2013
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 36

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

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

We met with one patient, two relatives, one member of care staff, one registered nurse and the resource manager.

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 18 April 2016

The most recent inspection of the home was an unannounced care inspection. A QIP was not issued following the inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 12 June 2014

<table>
<tr><th colspan="2">Last medicines management inspection recommendations</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 37

Stated: First time</td><td>The registered manager should ensure that any medicines which are deemed unsuitable or are discontinued are disposed of in the clinical waste bin by two members of designated staff and both staff should sign the record of disposal.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was evidence that two members of staff were involved in the disposal of medicines.</td></tr>
<tr><td rowspan="2">Recommendation 2

Ref: Standard 37

Stated: First time</td><td>The registered manager should review the management of distressed reactions to ensure the reason for the administration and outcome of the administration are recorded on every occasion.</td><td rowspan="2">Partially Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of records indicated that the reason and outcome of the administration of the medicine was not always recorded.

This recommendation was partially met and has been stated for a second time.</td></tr>
</table>

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. Training was completed by attendance at training sessions and the completion of e-learning modules. The registered manager advised of the current training programme for staff. This included a specific area of training per month. In relation to medicines management, this included general medicines management, diabetes, dementia awareness, palliative care and diet/nutrition. 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 when the patient was on a period of temporary leave 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 management of insulin was reviewed. Largely satisfactory arrangements were in place. Staff were reminded that the date of opening should be recorded on all insulin pens and that each insulin pen must be labelled. In accordance with best practice, it was suggested that the registered manager should consider the use of a separate record to state the number of units of insulin administered.

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. 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 audit trails performed on the sample of medicines examined indicated that medicines had been administered in accordance with the prescriber's instructions. Two discrepancies were observed in Schedule 4 controlled drugs. This was discussed and the registered manager advised that these may have been administered but not signed by the registered nurse. The need for robust systems for these medicines was discussed in relation to controlled drugs and the management of records for the treatment of distressed reactions. A recommendation regarding the auditing process was made.

There was evidence that time critical medicines had been administered on time. There were arrangements in place to alert staff of when doses of medicines prescribed at weekly, fortnightly or three monthly intervals 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 fully 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. A care plan was maintained for most of the patients. One care plan needed to be further developed and it was agreed that this would be completed as soon as possible. The reason for the administration and the outcome of the administration were not always recorded and the recommendation was stated for a second time.

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 some of the patients could verbalise pain. The management of pain was recorded in a care plan for some of the patients. However, for patients who could not verbalise pain or had little communication, there was no evidence that a pain assessment tool was in use or records of how staff would know the patient was in pain. The registered manager provided examples of how patients would communicate pain and it was acknowledged that the staff have worked in the home for several years and were knowledgeable regarding the patients' needs. The need to ensure that this information was clearly recorded was reiterated. A recommendation was made.

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. Each administration was 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. The good practice of recording alerts for those patients who were prescribed two medicines which contain paracetamol was acknowledged.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some anxiolytic medicines, antibiotics and nutritional supplements. In addition, a quarterly audit was completed by the community pharmacist. However, a small number of audit trails could not be concluded for some medicines which were administered on a “when required” basis, as there was no stock balances recorded and the medicine had been in use for some time. This should be reviewed.

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 in relation to medicine management.

Areas for improvement

The audit process for medicines should be reviewed to ensure that there are robust systems in place for the recording and administration of Schedule 4 controlled drugs and there are systems in place to facilitate the auditing of medicines administered on a “when required” basis. A recommendation was made.

The registered manager should review the management of distressed reactions to ensure the reason for the administration and outcome of the administration are recorded on every occasion. A recommendation was stated for a second time.

The management of pain should be reviewed to ensure that a pain assessment tool is used as applicable, and where pain relief medicines are prescribed, this is referenced in a care plan. A recommendation was made.

Number of requirements	0	Number of recommendations	3

4.5 Is care compassionate?

The administration of medicines to patients was completed in a caring manner. The patients were given time to take their medicines and medicines were administered as discreetly as possible.

It was noted that the patients came down for breakfast at a time which suited them and their medicines were administered at that time. The registered manager confirmed that appropriate time intervals between medicine rounds were adhered to.

A small number of patients were administered their medicines with yoghurt to aid swallowing. This was recorded in the care plan. It was agreed that pharmaceutical advice regarding the suitability of adding the medicine to yoghurt would be obtained.

The relatives spoken to at the inspection stated they were content with the care of their relative and spoke positively about the staff. They stated they had no concerns with the management of medicines and were complimentary regarding the management of medicines issued to their relative when on periods of temporary leave from the home.

The patient spoken to at the inspection advised that the medicines were given on time and that any request for medicines prescribed on a “when required” basis was adhered to e.g. external preparations and pain relief.

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 every few years. 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. However, it was noted that discrepancies continued to be found in the weekly audit trails. It was agreed that this would be reviewed and addressed with staff. (A recommendation regarding the auditing process 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.

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

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Miss Rhonda Murray, 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 taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to *pharmacists@rqia.org.uk* for review 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 28 **Stated:** Second time **To be completed by:** 13 July 2016	The registered manager should review the management of distressed reactions to ensure the reason for the administration and outcome of the administration are recorded on every occasion.
	Response by registered person detailing the actions taken: All patients who have been prescribed medication for distressed reactions now have a detailed care plan in place which is individualised to describe the signs, symptoms and triggers that they display which indicates the need for medication. New performa has been developed to ensure that weekly audits are carried out on the management of distressed reactions. The audits ensure that the reason and outcome of administration of distressed reactions medication are recorded in the daily notes. These audits are to be carried out by the Registered Manager or in her absense, the deputy manager. Importance of record keeping has also been addressed and reiterated with nursing staff.
Recommendation 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 13 July 2016	The registered provider should review the auditing process for medicines management as detailed in the report.
	Response by registered person detailing the actions taken: New performa has been developed for keeping a running balance on all 'When Required' medication which is audited on a monthly basis. Weekly audits are now performed on all Schedule 4 Controlled Drugs which will aid with the reduction of discrepancies. Weekly audits are also carried out on the management of medications used for distressed reactions that ensure records are maintained on the reason and outcome of administration.
Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 13 July 2016	The registered provider should review the management of pain to ensure this is fully detailed in the patient's records/care plan.
	Response by registered person detailing the actions taken: All patients who receive medication for pain now have a detailed care plan in place that clearly explains how they express their pain and what the indicators are. A choice of pain assessment tools are now available on our computerised system. These pain measuring tools are: The Abbey Pain Scale which can be used for patients who are unable to communicate their pain and for those who can communicate but require some assistance can use a pain chart that includes a pictorial scale (Wong/Baker faces rating scale).

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