Unannounced Medicines Management Inspection Report
28 June 2017

Castleview

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

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 36 beds that provides care for patients living with learning disability.

3.0 Service details

Organisation/Registered Provider: Castleview Private Nursing Home Ltd **Responsible Individual:** Mrs Lynda McCourt	**Registered Manager:** Miss Rhonda Murray
Person in charge at the time of inspection: Miss Rhonda Murray	**Date manager registered:** 19 August 2013
Categories of care: Nursing Home (NH) LD – Learning disability LD(E) – Learning disability – over 65 years	**Number of registered places:** 36

4.0 Inspection summary

An unannounced inspection took place on 28 June 2017 from 10.25 to 14.35.

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.

The inspection assessed progress with any areas for improvement identified during and since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to medicines administration, medicine records, storage and the management of controlled drugs.

No areas for improvement were identified.

Patients were relaxed and comfortable in their environment.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Miss Rhonda Murray, 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.

4.2 Action/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 11 April 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

- 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

During the inspection the inspector met with two patients, one registered nurse, one member of care staff, the registered manager and the resource manager,

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

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
- care plans
- training records
- medicines storage temperatures

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 11 April 2017

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

6.2 Review of areas for improvement from the last medicines management inspection dated 13 June 2016

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		Validation of compliance
Area for improvement 1 **Ref**: Standard 28 **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the management of distressed reactions had been reviewed. Two patients' records were examined. Details were recorded in their care plan. When administered the reason for and the outcome of the administration were recorded.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered provider should review the auditing process for medicines management as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The auditing of medicines management had been revised and new systems developed. Daily and weekly audits were completed. A list of specific audits to be completed each week was in place. Running stock balances were maintained for several medicines.	
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	The registered provider should review the management of pain to ensure this is fully detailed in the patient's records/care plan.	**Met**
	Action taken as confirmed during the inspection: The management of pain had been reviewed. Three patients' records were examined. Pain management was recorded in the patient's care plan and a pain assessment tool was available for use as needed. Pain controlling medicines were highlighted on the patient's personal medication record and a separate administration record was maintained; this included a running stock balance for the medicine.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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 year. A sample of records was provided at the inspection. The most recent training was in relation to dysphagia. The registered manager also advised of the staff nurses' role as designated link nurses regarding training for staff in areas such as epilepsy, diabetes, skin care and mental health. A list of staff names responsible for medicines management, delegated tasks and countersignatures for controlled drugs was maintained.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training was completed each year. In addition, the resource manager advised of her role in cascading safeguarding training, participation in working groups and ensuring that staff were up to date in their knowledge.

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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home; and for the management of medicine changes.

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 had been implemented for other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. insulin and anticoagulant injections. It was suggested that a running stock balance should be maintained for anticoagulant injectable medicines.

Some tablets are required to be crushed prior to administration. Written consent from the prescriber was in place.

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. New medicine trolleys had been brought into use. These 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 of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessment, the management of medicines on admission, controlled drugs and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There were arrangements in place to alert staff of when doses of weekly medicines were due.

The management of distressed reactions, swallowing difficulty and pain were reviewed. The relevant information was recorded in the patient's care plan, personal medication record and records of administration.

Epilepsy management plans were in place for patients prescribed rescue medicines for the treatment of seizures.

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.

A small number of patients were responsible for the self-administration of external preparations, on a 'when required' basis. Staff confirmed that this had been risk assessed in relation to patient competency and secure storage. The registered manager confirmed that this information would be recorded in the patient's care plan.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the separate administration records for insulin, transdermal patches, 'when required' medicines and double signatures on personal medication records for new medicines.

Following discussion with the registered manager and staff and a review of patients' records, it was evident that when applicable, other healthcare professionals were contacted in response to the patient's healthcare needs.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

There were arrangements in place to facilitate patients who were 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.

Throughout the inspection, it was evident that there was a good rapport between patients and staff. The staff treated the patients with respect and their approach was friendly and kind. They listened to the patients' requests.

We spoke with two patients at the inspection. Whilst we could not obtain their views or opinions about medicines management, they were relaxed and comfortable in their surroundings and interactions with staff.

Of the questionnaires that were issued, two were received from patients, one from a relative and three from staff. The responses indicated they very satisfied with all aspects of the care in relation to the management of medicines.

Areas of good practice

There was evidence that staff listened to patients and relatives and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

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. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

The governance arrangements for medicines were reviewed. Daily, weekly and monthly audits were completed. These included a variety of medicine formulations and the maintenance of running stock balances for specific medicines e.g. antibiotics, inhaled medicines, 'when required' medicines and nutritional supplements. This good practice was acknowledged. There was evidence that this system was well embedded into routine practice. Staff advised of the procedures that were followed if a discrepancy was identified.

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 medicines related concerns were raised with management. They advised that management were open and approachable and willing to listen. They stated that there were good working relationships within the home and with healthcare professionals involved in patients' care.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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