Unannounced Medicines Management Inspection Report
28 July 2016

The Cottage

Type of Service: Nursing Home
Address: 25 Lodge Park, Coleraine, BT52 1UN
Tel No: 028 7034 4280
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of The Cottage took place on 28 July 2016 from 10:30 to 16:00.

The inspection sought to assess progress with any issues raised 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.

Is care safe?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff were trained and competent. There were safe processes for the management of medicines changes and high risk medicines. One recommendation in relation to the cold storage of medicines was made.

Is care effective?

There was evidence that most areas of the management of medicines supported the delivery of effective care for patients. There were systems in place to ensure that patients were administered their medicines as prescribed, however, a requirement in relation to monitoring the administration of liquid medicines, inhaled medicines and weekly medicines was made. Satisfactory arrangements were in place for the management of pain. One recommendation in relation to care plans for distressed reactions was made.

Is care compassionate?

There was evidence that the management of medicines supported the delivery of compassionate care. Staff interactions with patients were observed to be compassionate, caring and timely. No requirements or recommendations have been made.

Is the service well led?

There was evidence that the service was well led with respect to the management of medicines. Written medicine policies and procedures were in place. There were robust systems to manage and share the learning from medication audits and medicine related incidents. 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	1	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Kathleen Holmes, 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 care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the inspection on 8 and 9 February 2016.

2.0 Service details

Registered organisation/registered provider: Merit Retail Limited Ms Therese Elizabeth Conway – Acting, no application required	**Registered manager:** Ms Kathleen Margaret Holmes
Person in charge of the home at the time of inspection: Ms Kathleen Margaret Holmes	**Date manager registered:** 1 April 2005
Categories of care: NH-TI, NH-DE, NH-I, NH-PH, NH-PH(E)	**Number of registered places:** 67

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, a relative, two care assistants, four registered nurses and the registered manager.

A sample of the following records was examined:

- 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 8 and 9 February 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 16 May 2013

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 37 **Stated:** First time	The registered manager should review and revise the management of warfarin.	**Met**
	Action taken as confirmed during the inspection: The management of warfarin had been reviewed and revised. Dosage directions were received in writing. Registered nurses referred to the original dosage directions at each administration. A separate recording sheet to record administration and running stock balances was maintained. The audits completed at this inspection produced satisfactory outcomes. A number of obsolete facsimiles detailing previous warfarin dosages were available on the medicines file; the registered nurse advised that this was an oversight and confirmed that they would be cancelled and archived without delay. Due to the progress made and assurances provided this recommendation has been assessed as met.	

Recommendation 2 **Ref:** Standard 38 **Stated:** First time	The registered manager should ensure that two nurses verify and sign hand-written updates on the medication administration records.	**No longer applicable**
	Action taken as confirmed during the inspection: This recommendation is no longer applicable, as pre-printed medication administration records were not being used.	
Recommendation 3 **Ref:** Standard 38 **Stated:** First time	The registered manager should ensure that two nurses are involved in the disposal of medicines and that both nurses sign the records for disposal.	**Met**
	Action taken as confirmed during the inspection: A review of the disposal records indicated that two nurses were involved in the disposal of medicines and both nurses had signed the records.	

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 supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management had been provided by the community pharmacist in June 2016.

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. One medicine was observed to be out of stock on the day of the inspection for a recently admitted patient; there was evidence that registered nurses had tried to obtain a supply prior to the medicine running out and that they had continued to contact the prescriber. Staff advised the medicine was due to be delivered later that day.

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. However, a number of the personal medication records had been laminated in an attempt to improve their durability; this made recording changes difficult. This had been identified by the management team who advised that the personal medication records were to be re-written using durable card.

There were safe 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.

Mostly satisfactory arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged. Registered nurses were reminded that insulin pens have a limited life once opened and must be discarded once the in use shelf life has been exceeded. Dosage directions for insulin had been abbreviated on one personal medication record; the registered manager confirmed that this would be discussed with all registered nurses for corrective action.

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

Discontinued or expired medicines were disposed of appropriately. Registered nurses confirmed that 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. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Oxygen was not chained securely in the Benone and Dunluce suites; the registered manager confirmed that this would be addressed later in the day. Some readings outside the accepted range were observed for the refrigerator temperatures and there was evidence that registered nurses were not resetting the thermometer each day. Guidance on using the thermometer was provided during the inspection. A recommendation was made.

Areas for improvement

The registered provider should ensure that the daily records of refrigerator temperature are reviewed by management regularly to ensure that medicines are being stored at the correct temperature. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

The majority of medicines examined had been administered in accordance with the prescriber's instructions. However, discrepancies in the administration of one weekly medicine, a liquid medicine and an inhaled medicine were observed. The registered provider must closely monitor the administration of these medicines. A requirement was made.

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. However detailed care plans were not place. The reason for and the outcome of administration were being recorded on some but not all occasions. In addition there was evidence that although some of these medicines needed to be administered on a regular basis, this had not been referred to the prescriber for review. A recommendation was made.

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. Detailed care plans were in place. Pain assessment tools were being used for patients who could not verbalise their pain. Staff also 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. 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. Some improvements in the standard of maintenance of the personal medication records were discussed and the registered manager confirmed that these would be addressed.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines and nutritional supplements. In addition, an audit was completed by the community pharmacist on a regular basis.

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 provider must closely monitor the administration of liquid form medicines, weekly medicines and inhaled medicines. A requirement was made.

The registered provider should review the management of distressed reactions. Detailed care plans should be in place. The reason for and outcome of each administration should be recorded. Where the medicine is needed regularly this should be referred to the prescriber for review. A recommendation was made.

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

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.

The patient we spoke with advised that he was very content in the home.

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

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. Staff were reminded that RQIA should be notified when medicines have been omitted as a result of stock shortages.

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

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

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff on an individual basis or via staff 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 Mrs Kathleen Holmes, 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 the 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

Statutory requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 29 August 2016	The registered provider must closely monitor the administration of liquid form medicines, weekly medicines and inhaled medicines.
	Response by registered provider detailing the actions taken: Daily Audits are in place to closely monitor the administration of liquid form medications, weekly medications and inhaled medicines.
Recommendations	
Recommendation 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 29 August 2016	The registered provider should ensure that the daily records of refrigerator temperature are reviewed by management regularly to ensure that medicines are being stored at the correct temperature.
	Response by registered provider detailing the actions taken: Weekly audits are in place to ensure that the daily records of refrigerator temperatures are closely and correctly monitored.
Recommendation 2 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 29 August 2016	The registered provider should review the management of distressed reactions. Detailed care plans should be in place. The reason for and outcome of each administration should be recorded. Where the medicine is needed regularly this should be referred to the prescriber for review.
	Response by registered provider detailing the actions taken: Care Plans are in place for the management of distressed reactions. Each administration reason and outcome is recorded. General Practitioners are informed if medication is needed on a regular basis.

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