Unannounced Medicines Management Inspection Report
14 March 2017

Craigdun Care Home

Type of Service: Nursing Home
Address: 30 Dunminning Road, Cullybackey, BT42 1PE
Tel no: 028 2588 0202
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Craigdun Care Home took place on 14 March 2017 from 09.40 to 13.00.

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. There were no areas for 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. There were no areas for improvement identified.

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. There were no areas for 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 for 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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Craigdun Care Home which provides both nursing and residential care.

1.1 Inspection outcome

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Susan Morgan, Registered Person and Mrs Marie McQuillan, Registered Nurse, 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.

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 2 March 2017.

2.0 Service details

Registered organisation/registered person: Sped Trading Ltd Mrs Susan Morgan	**Registered manager:** see box below
Person in charge of the home at the time of inspection: Mrs Marie McQuillan, Registered Nurse	**Date manager registered:** Mrs Lisa McDonald Acting – No Application required
Categories of care: NH-DE, NH-MP, NH-PH, NH-PH(E), NH-I, NH-TI, RC-I, RC-PH, RC-PH(E) 28 nursing: 5 residential. 2 named patients in category NH-DE, 1 named patient in category NH-MP and a maximum of 3 patients in category NH-TI.	**Number of registered places:** 33

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 two patients, the registered person, the registered nurse on duty and the administrator.

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:

- 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 2 March 2017

The most recent inspection of the home was an unannounced post-registration care inspection. A report will be issued and any resulting Quality Improvement Plan (QIP) will be returned and will be assessed 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 2 September 2015

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must ensure that systems are in place to manage the ordering of prescribed medicines to ensure adequate supplies are available.	**Met**
	Action taken as confirmed during the inspection: This was evidenced during the inspection. All of the prescribed medicines selected for examination were available.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37 **Stated:** Second time	It is recommended that the registered manager should ensure that the reason for and the outcome of the administration of 'when required' anxiolytic or antipsychotic medicines, in the management of distressed reactions, are recorded on every occasion.	**Met**

	Action taken as confirmed during the inspection: This was evidenced on most occasions. Details were sometimes recorded on a distressed reactions record sheet and sometimes in the daily notes. Staff were reminded that the reason for administration and the outcome should be recorded on every occasion that these medicines are administered. Since these details were recorded on most occasions this recommendation was not restated.	
Recommendation 2 **Ref**: Standard 4 **Stated: First time**	It is recommended that pain management care plans should be in place and that pain assessment tools should be used where appropriate.	**Met**
	Action taken as confirmed during the inspection: This was evidenced during the inspection. Detailed care plans were in place and a pain assessment tool was in use where appropriate.	

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 undertaking delegated tasks. The registered person advised that the impact of training would be monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was planned for registered nurses on 16 March 2017 and training in dysphagia and the use of thickening agents was planned for relevant staff in the coming weeks.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. The registered nurse advised of the procedures to identify and report any potential shortfalls in medicines.

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.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

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. warfarin and 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 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. Staff were reminded that the refrigerator thermometer must be reset after recording temperatures. Any deviation outside of the required temperature range for the cold storage of medicines (2-8○C) should be investigated.

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 had been administered in accordance with the prescriber's instructions. There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due. Staff were reminded that the date of opening should be recorded on every medicine to facilitate audit.

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 the outcome of administration were usually 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.

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. 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. Areas of good practice were acknowledged.

Practices for the management of medicines were audited throughout the month by the staff and management. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered nurse, it was evident that other healthcare professionals are contacted when required to meet the needs of patients.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients were treated courteously, with dignity and respect. Good relationships were evident.

We spoke briefly to two patients during the inspection. No concerns were raised regarding the management of medicines.

As part of the inspection process, questionnaires were issued to patients, relatives/patients' representatives and staff. One service user questionnaire and one relative questionnaire were returned within the specified timescale. Replies indicated that there were no concerns with the management of medicines in the home.

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. The registered person advised that these would be reviewed since the home has recently been registered with a new provider.

There were robust arrangements in place for the management of medicine related 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.

Following discussion with the registered nurse and registered person, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Following discussion with the registered nurse on duty, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management and that any concerns in relation to medicines management were raised with management.

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.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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