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Unannounced Medicines Management Inspection of Chester

7 September 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced medicines management inspection took place on 7 September 2015 from 10:35 to 14:20.

Overall on the day of the inspection the management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no significant areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

This inspection was underpinned by the 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 Chester which provides both nursing and residential care.

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last medicines management inspection on 13 December 2013.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	0

The details of the QIP within this report were discussed with Ms Gillian Dowds, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Chester Homes Ltd Mr Robert Desmond Wilson	**Registered Manager:** Ms Gillian Dowds
Person in Charge of the Home at the Time of Inspection: Ms Gillian Dowds	**Date Manager Registered:** 24 July 2014
Categories of Care: RC-LD, RC-MP(E), RC-DE, NH-PH, NH-DE	**Number of Registered Places:** 43 (40 effective)
Number of Patients Accommodated on Day of Inspection: 40	**Weekly Tariff at Time of Inspection:** £470 – £591

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and to determine if the following standards and themes have been met:

Standard 28: Management of Medicines
Standard 29: Medicines Records
Standard 31: Controlled Drugs

Theme 1: Medicines prescribed on a "when required" basis for the management of distressed reactions are administered and managed appropriately

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to the inspection, the inspector reviewed the management of medicine related incidents reported to RQIA since the last medicines management inspection.

During the inspection the inspector met with the registered manager, staff on duty and one resident's visitor.

The following records were examined during the inspection:

Medicines requested and received
Personal medication records
Medicines administration records
Medicines disposed of or transferred
Controlled drug record book
Medicine audits
Policies and procedures
Care plans
Training records
Medicine storage temperatures.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced care inspection dated 14 May 2015. No requirements or recommendations were made following the inspection.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Inspection

Last Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 13(1) Stated twice	The registered manager must ensure that the care plans for the patients/residents who require the administration of medicines in food, to aid swallowing, are up to date and reflect this arrangement.	**Met**
	Action taken as confirmed during the inspection: A detailed care plan regarding the administration of medicines in food was evidenced at the inspection.	
Requirement 2 **Ref**: Regulation 13(4) Stated twice	The registered person must ensure that the time of administration recorded, accurately reflects the practice in the home.	**Met**
	Action taken as confirmed during the inspection: Examination of the administration of medicines records indicated that medicines had been administered on time and the administration had been recorded accurately.	
Requirement 3 **Ref**: Regulation 13(4) Stated once (carried forward)	The registered manager must ensure robust arrangements are in place for the management of warfarin.	**Met**
	Action taken as confirmed during the inspection: The management of warfarin was in accordance with safe practice. Written confirmation of warfarin regimes was obtained and any transcribing of dosage regimes involved two registered nurses. A separate administration record which included a daily stock balance was in place. There were no discrepancies noted in the warfarin audited at the inspection.	

Last Inspection Statutory Requirements		Validation of Compliance
Requirement 4 **Ref**: Regulation 13(4) Stated once	The registered manager must review the deployment of staff to ensure patients' medicines are administered as near to the time prescribed at all times.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that staffing levels between the hours of 08:00 to 11:00 had been reviewed. There was no evidence of any delay in the administration of medicines at the time of the inspection.	

Last Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 38 Stated once	The registered person should review the procedures for recording the administration of external preparations by nursing staff and care staff.	**Met**
	Action taken as confirmed during the inspection: This area of medicines management had been reviewed. Records stated which external preparations were administered by registered nurses and care staff. Management had introduced separate folders containing administration records for the relevant patients. A recent audit had highlighted some improvement was necessary to ensure that all administrations were recorded. The registered manager advised of the action which had been taken and the planned follow up action. This included a designated staff member to audit these records and also the provision of refresher training.	
Recommendation 2 **Ref**: Standard 39 Stated once	The registered person should risk assess the storage of external preparations in patients' bedrooms.	**Met**
	Action taken as confirmed during the inspection: A risk assessment had been carried out and was located in the risk assessment folder. This had been read and signed by staff.	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

Medicines were administered in accordance with the prescriber's instructions. The audit trails performed on a variety of randomly selected medicines at the inspection provided satisfactory outcomes. There was evidence that bisphosphonate medicines had been administered at the correct time.

Robust arrangements were in place to ensure the safe management of medicines during a patient's admission to the home.

The process for the ordering and receipt of medicines was reviewed. Prescriptions were received into the home and checked for accuracy before being dispensed. Medicines were only ordered as needed and there were systems in place to ensure that there was a continuous supply of medicines.

At the time of the inspection, medicines were prepared immediately prior to their administration from the container in which they were dispensed. All of the medicines examined at the inspection were labelled appropriately.

With the exception of some personal medication records, medicine records were accurately maintained so as to ensure that there was a clear audit trail. Records of the ordering, receipt, administration, non-administration and disposal of medicines were maintained. All of the personal medication records examined were written and signed by two registered nurses, this is safe practice, however, as some non-correlation between the personal medication records and corresponding medication administration records was found, this area must be reviewed.

In April 2015, the registered manager had introduced the use of a communication book to record any new information regarding the patients, e.g. changes in medicines.

Satisfactory arrangements were in place for the management of controlled drugs. Stock reconciliation checks were performed on controlled drugs, which are subject to the safe custody legislation at each transfer of responsibility. There were separate records maintained to record the application and removal of controlled drug patches. This is good practice. The management of Schedule 4 controlled drugs was discussed with regard to specific audits on any medicines which are administered infrequently. The registered manager advised that this would be reviewed with the aim to commence daily stock balance checks.

There are suitable systems in place to manage any high risk medicines e.g. warfarin, insulin.

The management of thickening agents was reviewed. Speech and language assessment reports were in place and the thickening agent was recorded on the personal medication record. The prescribed consistency level should also be recorded on this record. It was acknowledged that this is detailed on the administration records.

Two registered nurses were involved in the disposal of any medicines which were discontinued or were unsuitable for use. These medicines were uplifted by a company holding a clinical waste licence. Controlled drugs were denatured prior to disposal using denaturing kits.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines including Standard Operating Procedures for controlled drugs in Chester were in place. These had been reviewed in August 2015.

Medicines were managed by staff who have been trained and deemed competent to do so. The impact of training was monitored through team meetings, supervision and annual appraisal. A sample of training records and competency assessments were provided. Upcoming training includes the completion of e-learning modules in general medicines management, the management of dysphagia and external preparations. A list of the names, signatures and initials of trained staff was maintained.

Practices for the management of medicines were audited on a regular basis. Running stock balances were maintained for warfarin and several other medicines which were not included in the 28 day blister packs e.g. analgesics, benzodiazepines, Calogen liquid. This is good practice. The registered manager and community pharmacist had also completed audits. Staff had routinely recorded the balance of any medicines remaining from the previous medicine cycle to facilitate the audit process.

There were procedures in place to report and learn from any medicine related incidents that had occurred in the home. The reported incidents had been managed appropriately.

There were arrangements in place to note any compliance issues with medicine regimes and these were reported to the patient's prescriber.

Is Care Compassionate? (Quality of Care)

The records pertaining to a small number of patients who were prescribed medicines on a "when required basis" for the management of distressed reactions were observed at the inspection. The parameters for administration of anxiolytic medicines were recorded on the personal medication records. A care plan was maintained and evaluated monthly. The audits indicated that these medicines were administered infrequently. A separate record of each administration was maintained and included the reason for the administration and a stock balance. This is good practice. A record of the administration was also maintained in the patient's daily notes. However, there were no details in relation to the outcome or effect of the administration and this should be recorded. From discussion with the staff, it was concluded that staff were familiar with circumstances when to administer anxiolytic medicines. Staff had the knowledge 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.

Medicines which were prescribed to manage pain were recorded on the patient's personal medication record. Examination of the administration of medicines which were prescribed to treat or prevent pain indicated that these medicines had been administered as prescribed. This included regularly prescribed controlled drug patches and analgesics which were prescribed for administration on a "when required" basis. A pain score chart for analgesics was completed for each administration and detailed the level and area of pain and also included a running stock balance. This is good practice. From discussion with the registered nurses, it was evident that staff were aware of the signs, symptoms and triggers of pain in patients. Where pain controlling medicines were prescribed, staff were aware that ongoing monitoring is necessary to ensure the pain was well controlled and the patient was

comfortable. Care plans in relation to pain management were in place and were evaluated each month. A pain tool was in use.

Areas for Improvement

The standard of maintenance of personal medication records must be reviewed to ensure that these are kept up to date at all times. A requirement was made.

Staff were reminded that the prescribed consistency level of thickened fluids should be routinely recorded on the personal medication records. It was agreed that this would be updated at the earliest opportunity.

When staff administer anxiolytic medicines to patients for the treatment of distressed reactions, details of the outcome of the administration should be recorded on every occasion. The registered manager confirmed that this would be recorded from the day of the inspection onwards.

Number of Requirements:	1	**Number of Recommendations:**	0

5.4 Additional Areas Examined

Medicines were stored safely and securely in accordance with the manufacturers' instructions. For medicines which have a limited shelf-life once opened, the date of opening was recorded.

6. Quality Improvement Plan

The issue identified during this inspection is detailed in the QIP. Details of this QIP were discussed with Ms Gillian Dowds, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered manager/registered person 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 person/manager 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 your premises. 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The DHPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes (2015). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP should be completed by the registered manager/registered person and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to pharmacists@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated: First time** **To be Completed by:** **7 October 2015**	The registered person must make the necessary arrangements to ensure that personal medication records are kept up to date at all times.
	Response by Registered Person(s) Detailing the Actions Taken: medication records are currently being updated and staff are to ensure all medication changes are updated immediately

Registered Manager Completing QIP	G Dowds	**Date Completed**	29/9/15
Registered Person Approving QIP	D Wilson	**Date Approved**	29.09.15
RQIA Inspector Assessing Response	Judith Taylor	**Date Approved**	15.10.15

Please ensure the QIP is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address