Unannounced Medicines Management Inspection Report
12 January 2017

Kintullagh Care Home

Type of Service: Nursing Home
Address: 36 Westbourne Avenue, Carniny Road, Ballymena, BT43 5LW
Tel no: 028 2565 4444
Inspectors: Judith Taylor and Frances Gault

1.0 Summary

An unannounced inspection of Kintullagh Care Home took place on 12 January 2017 from 09.50 to 14.25.

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 that the management of medicines was in compliance with legislative requirements and standards. There were no requirements of recommendations made.

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. Care plans relating to medicines management were maintained. Two areas for improvement were identified in relation to record keeping and filing of records; two recommendations were made.

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. Patients consulted with confirmed that they were administered their medicines appropriately. There were no requirements or recommendations made.

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 requirements or recommendations 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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Kintullagh 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	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Jill O'Neill, 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 most recent inspection on 19 July 2016.

2.0 Service details

Registered organisation/registered person: Runwood Homes Ltd Mr John Rafferty	**Registered manager:** Ms Jill O'Neill
Person in charge of the home at the time of inspection: Ms Jill O'Neill	**Date manager registered:** 14 April 2016
Categories of care: NH-I, NH-PH, NH-LD, RC-I, RC-MP(E), RC-PH(E)	**Number of registered places:** 61

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 three patients, three registered nurses, three care staff, the activities therapist/co-ordinator and the registered manager.

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-six questionnaires were issued to patients, relatives/patient representatives and staff, with a request that these be returned within one week of the inspection.

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 19 July 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.

One of the recommendations made at that inspection was in relation to the temperature of the treatment room and the storage of medicines in this room. There was evidence of the action taken and examination of the records indicated that the daily treatment room temperature was satisfactory.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 2 June 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** Second time	The responsible individual should review the management of medicines prescribed for distressed reactions to ensure the relevant records are maintained as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The patients' records examined, evidenced that care plans and records of the reason for and outcome of any administration were in place.	

Recommendation 2 **Ref**: Standard 4 **Stated:** First time	It is recommended that the registered person should review the management of pain to ensure that a detailed care plan is maintained for patients prescribed medicines to manage pain; pain is reviewed following admission and a pain assessment tool is maintained for those patients who cannot verbally express pain.	**Met**
	Action taken as confirmed during the inspection: Staff and management confirmed that a pain assessment was completed for new patients and each patient in the home. They were aware of the importance of this for patients who could not verbalise pain. A sample of completed pain assessments was observed. Care plans were in place. In addition, a separate record was maintained to record the reason for and outcome of any administration of pain controlling medicines which were prescribed for "when required" use.	

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 team meetings, supervision and annual appraisal. Competency assessments were completed annually. A sample of competency assessments for registered nurses and care staff was provided at the inspection. The format of these regarding thickening agents and external preparations was commended. The registered manager advised of the training in place pertaining to medicines and also discussed the In Reach programme, which included refresher training in the management of diabetes, enteral feeding, syringe drivers and epilepsy.

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 discharge from the home.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. A care plan was in place.

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. Staff were reminded that the correct brand of buprenorphine patches must be recorded in the controlled drugs record book. It was suggested that where different brands are supplied, the page should be titled buprenorphine.

Appropriate arrangements were in place for administering medicines in disguised form. A care plan 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. Medicine storage areas were clean and tidy. 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. In the first floor treatment room, there was limited space to store oral nutritional supplements and as result, these were stored directly on the floor. This was discussed with the registered manager and it was agreed that this would be reviewed.

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 majority of medicines examined had been administered in accordance with the prescriber's instructions. Queries were raised in relation to two medicines and these were discussed with the registered manager, who confirmed that she would examine and advise us of the outcome. On 13 January 2017, she provided the explanation by telephone to the senior pharmacist inspector.

There was evidence that time critical medicines had been administered at the correct time. Despite the arrangements in place to alert staff of when doses of weekly, three weekly or three monthly medicines were due, it was found that controlled drug patches had not always been administered at seven day intervals for one patient, and for another patient an injection had been administered late. This should be reviewed to ensure that all medicines are administered as prescribed. A recommendation 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. The reason for and the outcome of administration were recorded. A care plan was maintained.

The management of pain was examined. Staff advised that a pain assessment was completed for all patients in the home and was assessed on a monthly basis. Pain management was detailed in the sample of care plans examined. With the exception of the controlled drug patches discussed above, the sample of records examined indicated that pain controlling medicines had been administered as prescribed. Staff were aware of the need to ensure that the pain was well controlled and the patient was comfortable. The good practice of maintaining a record of the reason for and outcome of any administration of analgesics was acknowledged.

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 were reminded that details of the fluid consistency should also be recorded on the administration records. It was agreed that this would be addressed.

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. Two patients' medicines were discussed. A care plan was in place.

Medicine records including fluid charts pertaining to enteral feeding were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the use of separate administration charts for high risk medicines, antibiotics, injectable medicines and medicines prescribed on a "when required" basis. It was recommended that the filing of completed medicine records should be reviewed to ease retrieval for review.

The staff spoken to at the inspection were very positive about their work, the relationships between staff and the support provided by the staff team and the registered manager. The enthusiasm of staff was acknowledged.

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 relating to medicines management.

Areas for improvement

The management of medicines prescribed on weekly/three weekly basis should be reviewed. A recommendation was made.

The arrangements for the filing of all medicine records should be reviewed. A recommendation was made.

Number of requirements	0	**Number of recommendations**	2

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.

Following discussion with staff, it was clear that the staff were familiar with the patients' needs, their likes and dislikes. They advised of how patients enjoyed the activities of their preference and spoke positively regarding the introduction of 'spa' treatments by the activities therapist.

Throughout the inspection, it was found that there were good relationships between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity.

The patients spoken to had no concerns regarding the management of their medicines and advised that staff responded in a timely manner to any requests for pain relief or care. They were very complimentary regarding the care provided by the staff and the registered manager.

Their comments included:

"They are first class."
"You couldn't ask for anything better."
"Nurse XX is like a doctor."
"Girls are lovely, very efficient."

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.

As part of the inspection process, 26 questionnaires were issued to patients, relatives/patient representatives and staff. Questionnaires were competed and returned by one relative/patient representative at the time of issuing the report. The responses were recorded as 'very satisfied' and 'satisfied' 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. These included the organisation's generic policies and also local policies specific to Kintullagh Care Home. 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. They advised of the procedures in place and how any learning was shared with staff.

An effective auditing system was in place and included daily, weekly and monthly auditing by staff and management. Where discrepancies or areas for improvement were identified, an action plan was developed and followed up by the registered manager. In addition, an audit was completed by the community pharmacist on a regular basis.

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 advised that the registered manager was very approachable and willing to listen. They provided some examples at the inspection.

As part of the communication processes in the home, the registered manager advised that a daily meeting was held with registered nurses. She stated that this meeting was in addition to the verbal and written information provided at each shift change and this ensured the completion of daily tasks to meet the patients' needs.

Staff confirmed that any concerns in relation to medicines management were raised with management.

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 the QIP were discussed with Ms Jill O'Neill, 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 to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to the **web portal** for assessment 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:** First time **To be completed by:** 12 February 2017	The registered provider should further develop the systems in place to ensure that medicines prescribed on weekly/three weekly basis are administered as prescribed.
	Response by registered provider detailing the actions taken: Registered Manager reviewed systems in place and noted that medications prescribed on weekly/three weekly basis are not always entered into the nurses diary,this has recommenced going forward. The resident prescribed patches had a rash noted on removal of patch GP had instructed staff to let area heal before reapplying, this would explain the 2 days between application of new patch on 2 concurrent dates. GP has since discontiued the patch for oral MST twice daily
Recommendation 2 **Ref**: Standard 37 **Stated:** First time **To be completed by:** 12 February 2017	The registered provider should review the arrangements for the filing of all medicine records.
	Response by registered provider detailing the actions taken: All resident records are filed together in a folder on a monthly basis Going forward medication records will be kept at the back of the monthly folder in a separate polypocket

Please ensure this document is completed in full and returned to the web portal

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews