Unannounced Medicines Management Inspection Report
14 January 2019

Kintullagh Care Home

Type of Service: Nursing Home
Address: 36 Westbourne Avenue, Carniny Road, Ballymena, BT43 5LW
Tel No: 028 2565 4444
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 that provides care for up to 61 patients living with healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Mr Gavin O'Hare-Connolly	**Registered Manager:** See box below
Person in charge at the time of inspection: Mrs Nuala Doherty (Deputy Manager)	**Date manager registered:** Mrs Julie-Ann Jamieson (application received - registration pending)
Categories of care: Nursing Homes (NH) I – Old age not falling within any other category LD – Learning disability PH – Physical disability other than sensory impairment	**Number of registered places:** 61 including: a maximum of one named patient in Category NH-LD a maximum of three named residents receiving residential care in category RC-I

4.0 Inspection summary

An unannounced inspection took place on 14 January 2019 from 10.15 to 15.45.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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 governance, training and competency assessment, the management of controlled drugs, the standard of record keeping, care planning and the safe storage of medicines. The progress made in addressing the issues identified at the last medicines management inspection was acknowledged.

No areas for improvement were identified at the inspection.

The patient and relative we met with spoke positively about the staff and the care provided. There was a warm and welcoming atmosphere in the home and the patients were observed to be 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 Mrs Nuala Doherty, Deputy Manager and one other member of staff, 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

No further actions were required to be taken following the most recent inspection on 18 December 2018. 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

A poster was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

During the inspection we met with one patient, one relative, two registered nurses, the nursing sister, three care assistants, the deputy manager and the administrator.

A sample of the following records was examined during the inspection:

- medicines received
- personal medication records
- medicine administration records
- medicines disposed of
- controlled drug record books
- medicine audits
- care plans
- training and competency records
- medicine storage temperatures
- medicine policies and procedures

We provided 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA and we asked the staff to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

We left ‘Have we missed you?’ cards in the home to inform patients and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

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 18 December 2018

The most recent inspection of the home was an unannounced care inspection. There were no areas for improvement identified as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 5 January 2018

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall review the stock control of medicines to ensure that all medicines are available for administration and any shortfalls are readily identified and reported to management.	**Met**
	Action taken as confirmed during the inspection: There was no evidence of any out of stock medicines at the inspection. A new medicine system had been implemented and staff advised of the processes in place to ensure continuity of medicine supplies.	
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall investigate the observations made in the administration of one identified injection; a written report of the findings and action taken should be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: A written report was forwarded to RQIA. All of the injections selected for examination were within the expiry date.	

Area for improvement 3 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall review the governance arrangements for medicines management to ensure that these are robust.	**Met**
	Action taken as confirmed during the inspection: The governance arrangements for medicines had been reviewed. We were advised of the audits completed by staff and management, the frequency of these and the support from the community pharmacist. A "patient of the day" audit had also been implemented. It was evident from the inspection outcomes that robust systems to oversee medicines management were now in place.	
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:** First time	The registered person shall ensure that all Schedule 4 (Part 1) controlled drugs are denatured prior to disposal.	**Met**
	Action taken as confirmed during the inspection: Staff confirmed that they knew that all Schedule 4 (Part 1) controlled drugs must be denatured before disposal. Details of the disposal were clearly recorded in the medicine disposal records.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered manager shall closely monitor the administration of liquid medicines to ensure that these are administered as prescribed.	**Met**
	Action taken as confirmed during the inspection: Liquid medicines were included in the audit process. The audit outcomes showed significant improvement in the administration of these medicines.	

Area for improvement 3 **Ref**: Standard 28 **Stated:** First time	The registered person shall develop systems to ensure that the management of external preparations is robust.	**Met**
	Action taken as confirmed during the inspection: There was evidence of improvement in the management of external preparations. However, there were some incomplete records noted for a small number of patients. These were highlighted to staff and most of these medicines were for administration "as required" or were no longer prescribed. A deputy manager had been recently appointed and she advised of her role in governance and audit and stated that this had been identified. She assured that this would continue to be a focus. Given these assurances this area for improvement was assessed as met.	
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that all handwritten information in the care plans is legible.	**Met**
	Action taken as confirmed during the inspection: All of the care plans selected at the inspection were legible.	
Area for improvement 5 **Ref**: Standard 28 **Stated:** First time	The registered person shall review the management of thickening agents to ensure that records clearly indicate the prescribed consistency and that care staff have information readily available at administration.	**Met**
	Action taken as confirmed during the inspection: Improvement in the management of thickening agents was evidenced. We reviewed several patients' records. Details of the prescribed consistency level were clearly recorded on the personal medication records, on printed medication administration records and also on most of the records completed by care staff. A specific folder for care staff was in place and included a copy of the patient's speech and language assessment report for reference. We were advised of the auditing systems for these records.	

Area for improvement 6 **Ref**: Standard 28 **Stated:** First time	The registered person shall review the management of self-administered medicines to ensure that a care plan is maintained.	**Met**
	Action taken as confirmed during the inspection: There were no patients responsible for the self-administration of medicines. The completed QIP stated that this had been addressed after the last medicines management inspection. Policies and procedures to manage self-administration were in place.	

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. A sample of training and competency records was provided.

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. Written confirmation of medicine regimes and any medicine changes were obtained. Personal medication records and medication administration records were updated by two trained staff. This is safe practice was acknowledged.

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, report and follow up any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed.

The management of controlled drugs was reviewed. 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. Care plans were maintained.

Discontinued or expired medicines, including controlled drugs, were disposed of appropriately.

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 robust systems to manage medicines which required cold storage. Largely satisfactory systems were in place to manage medicines with a limited shelf life once opened; however, one expired medicine was removed and replaced at the inspection. It was agreed that this would be discussed with staff. Oxygen equipment was checked on a regular basis.

Areas of good practice

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

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.

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. One discrepancy was discussed with staff to review and follow up with the prescriber if necessary.

There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of twice weekly, weekly or three monthly medicines were due.

The management of pain and distressed reactions was reviewed. Medicine details were recorded on the personal medication records. Care plans were maintained. Staff were aware that distressed reactions may be the result of pain and that ongoing monitoring was necessary to ensure that the patient was comfortable. Specific administration records were in use to enable staff to record the reason for and outcome of any administration.

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. Care plans and speech and language assessment reports were in place. Records of administration were completed by registered nurses and care staff. See also Section 6.2

Staff advised 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 patient's family and prescriber.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for transdermal patches and injectable medicines and protocols for "when required" medicines. In relation to personal medication records, a few of these required updating. It was acknowledged that these were being rewritten by staff during the inspection.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several medicines and recording the quantity of medicine carried forward to the next medicine cycle. A quarterly audit was also completed by the community pharmacist.

Following discussion with the management and staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to patients' healthcare needs. We were provided with examples in relation to swallowing difficulty, distressed reactions, infection and skin care.

Areas of good practice

There were examples of good practice 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.

The administration of medicines to patients was not observed during the inspection. Following discussion with staff it was evident they were knowledgeable about the patients' medicines and how the patients preferred to take their medicines.

We noted the warm and welcoming atmosphere in the home. Throughout the inspection, it was found that there were good relationships between the staff, the patients and the patients' representatives. Staff were noted to be friendly and courteous and engaged with patients and relatives/visitors. It was clear from observation of staff, that they were familiar with the patients' likes and dislikes.

We met with one patient who was complimentary about the care provided, the food and the staff. She advised us of her experiences in the home. Comments included:

"The staff are very good here. I have no complaints at all."
"I am looked after well and I eat well."

We also met with one relative. He spoke positively about the staff and the care and stated he had no concerns.

Of the questionnaires, which were left in the home to receive feedback from patients/their representatives, none were returned within the specified time frame (two weeks). Any comments in questionnaires received after the return date will be shared with the manager as necessary.

Areas of good practice

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.

We discussed arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. Arrangements were in place to implement the collection of equality data.

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. We discussed the medicine related incidents reported since the last medicines management inspection. 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 team.

The governance arrangements for medicines management were examined. There was evidence of auditing and monitoring systems to ensure sustained improvement. We were advised of the daily, weekly and monthly audits completed regarding medicines records and care plans, and how areas for improvement were shared with staff to address.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with the management team.

Staff advised there were effective communication systems in place to ensure that they were kept up to date. In addition to the written and verbal shift handover reports, a 24 hour report was shared with the manager for her attention and action as required.

The staff spoke positively about their work and advised there were good working relationships in the home and with other healthcare professionals. They stated they felt well supported in their work and had no concerns.

No online questionnaires were completed by staff within the specified time frame (two weeks).

Areas of good practice

There were examples of good practice 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.

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