Antrim Care Home
RQIA ID: 1434
88 Milltown Road
Antrim
BT41 2JJ

Inspector: Judith Taylor
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Unannounced Medicines Management Inspection of Antrim Care Home

27 April 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced medicines management inspection took place on 27 April 2015 from 10:30 to 15:50.

Overall on the day of the inspection the management of medicines was found to be safe, effective and compassionate. The outcome of the medicines management inspection found no significant areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) appended to 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. RQIA will continue to monitor any recommendations made under the 2008 standards until compliance is achieved. Please also refer to Section 5.2 and 6.2 of this report.

This inspection was underpinned by the DHSSPS Care Standards for Nursing Homes (2015).

For the purposes of this report the term 'patients' will be used to describe those living in Antrim Care Home 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 6 September 2012.

1.2 Actions/Enforcement Resulting from this Inspection

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

An urgent action record regarding the administration of mirtazapine prescribed for one patient was issued to the nursing sister at the end of the inspection. The action is required to be addressed without delay to ensure the safety and wellbeing of patients.

A written response was received on 1 May 2015.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**3**	**4**

The details of the QIP within this report were discussed with Mrs Diana Pahome (Nursing Sister) as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Four Seasons Health Care/ Dr Maureen Claire Royston	**Registered Manager:** Mrs Shirley Martin
Person in Charge of the Home at the Time of Inspection: Mrs Diana Pahome (Nursing Sister)	**Date Manager Registered:** 12 February 2015
Categories of Care: RC-I, NH-DE, NH-I, NH-PH, NH-PH(E), NH-TI	**Number of Registered Places:** 53
Number of Patients Accommodated on Day of Inspection: 35	**Weekly Tariff at Time of Inspection:** £470 - £637

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 nurse in charge. The on call manager from Four Seasons Health Care, Mr John Coyle was also present during part of the inspection.

The following records were examined during the inspection:

Medicines requested and received
Personal medication records
Medicines administration records
Medicines disposal records
Controlled drug record book
Policies and procedures
Medicine audits
Training records
Care Plans
Medicine storage temperature records

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced estates inspection dated 19 December 2014. The completed QIP was returned to RQIA on 17 February 2015. Some issues required clarification and are being followed up by the estates inspection team.

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(4) Stated once	The registered manager must closely monitor the administration of inhaled medicines. Any further discrepancies must be investigated and reported to RQIA.	**Met**
	Action taken as confirmed during the inspection: With the exception of one inhaled medicine, the audit trails which were performed on inhaled medicines produced satisfactory outcomes. One inhaled medicine could not be audited as the incorrect date of opening had been recorded. It was agreed that a base level would be taken and the inhaler audited from the day of the inspection onwards.	
Requirement 2 **Ref**: Regulation 13(4) Stated once	Where care staff are responsible for the administration of external preparations, records of training and competency must be maintained.	**Met**
	Action taken as confirmed during the inspection: There was evidence that care staff had been trained and deemed competent in the administration of external preparations.	

Last Inspection Statutory Requirements		Validation of Compliance
Requirement 3 **Ref:** Regulation 13(4) Stated once	The registered manager must ensure that personal medication records are fully and accurately maintained at all times.	**Partially Met**
	Action taken as confirmed during the inspection: Most of the personal medication records examined at the inspection had been maintained in the required manner. A few discrepancies were highlighted at the inspection and some of these were corrected during the inspection. The nursing sister advised that all personal medication records would be rewritten following the inspection.	
Requirement 4 **Ref:** Regulation 13(4) Stated once	The registered manager must ensure that all medicines are administered as prescribed and records of administration are accurately maintained.	**Partially Met**
	Action taken as confirmed during the inspection: Whilst the majority of medicines had been administered as prescribed and the records had been completed, it was noted that there were no records of administration of one nutritional supplement or one patient's thickening agent; two controlled drug patches had been administered late and there were missing signatures for one medicine. The audit trails on several liquid medicines indicated discrepancies. **This requirement has been restated**	

Last Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref:** Standard 38 Stated twice	In the absence of GP verification, two competent members of staff should verify and sign medicine entries on the personal medication records.	**Partially Met**
	Action taken as confirmed during the inspection: This practice occurs on some, but not all occasions. The nursing sister advised that this is the expected practice of the staff and it was agreed that as personal medication records were to be rewritten, this issue would be further discussed with the registered manager to address.	
Recommendation 2 **Ref:** Standard 39 Stated once	A list of medicines which require cool storage should be obtained and displayed in the treatment room.	**Met**
	Action taken as confirmed during the inspection: This list was displayed on the medicine refrigerator in each treatment room	
Recommendation 3 **Ref:** Standard 37 Stated once	The registered manager should ensure that control checks on blood glucometers are performed each week in accordance with the home's policy.	**Met**
	Action taken as confirmed during the inspection: Quality control checks on blood glucometers are monitored and the outcomes recorded on a weekly basis.	

Last Inspection Recommendations		Validation of Compliance
Recommendation 4 **Ref:** Standard 37 & 38 Stated once	When a thickening agent is prescribed, the registered manager should ensure that the required consistency level of thickened fluid is recorded on the personal medication records and administration records.	**Partially Met**
	Action taken as confirmed during the inspection: The prescribed consistency level of thickening agents was recorded on the personal medication records and medication administration records in the general nursing unit, but this was not evidenced in the dementia unit. The nursing sister advised that this would be addressed later on the day of the inspection.	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

The majority of 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 are in place to ensure the safe management of medicines during a patient's admission to the home and on their discharge from the home.

The process for the ordering and receipt of medicines was reviewed. Prescriptions are received into the home and checked for accuracy before being dispensed. Medicines are only ordered as the need arises and there are systems in place to ensure there is 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.

Most of the medicine records were legible and 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 had been written and signed by two registered nurses to ensure the accuracy of the record. This is safe practice.

Satisfactory arrangements are in place for the management of insulin and blood glucose monitoring.

Any medicines which are discontinued or are unsuitable for use are disposed of by two registered nurses and are uplifted by a clinical waste company. Controlled drugs are denatured prior to disposal.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines including Standard Operating Procedures for controlled drugs in Antrim Care Home are in place.

Medicines are managed by staff who have been trained and deemed competent to do so. The impact of training is monitored through team meetings, supervision and annual appraisal. Competency assessments are completed annually. Training in general medicines management for registered nurses is provided through training sessions and completion of e-learning modules. The most recent training had been completed in February 2015. In the last year, care staff who are responsible for delegated medicines related tasks have been provided with training in the management of dysphagia and the application of external preparations.

There are arrangements in place to audit the practices for the management of medicines. Registered nurses complete daily stock balances for a number of medicines which are not included in the 28 days blister packs. Weekly and monthly audits are also completed. Stock reconciliation checks are performed on controlled drugs at each transfer of responsibility. A review of the audit records indicated that largely satisfactory outcomes had been achieved. The audit process is facilitated by the good practice of recording the date and time of opening on the medicine container on most occasions. Some areas which staff had already identified through the audit process and had reported for improvement were discussed during the inspection.

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

Records are maintained to ensure that the next dose of an injectable medicine is clearly referenced.

Is Care Compassionate? (Quality of Care)

There was written evidence from a health care professional regarding the administration of medicines which require to be crushed prior to administration.

The records pertaining to a small number of patients who are prescribed medicines for the management of distressed reactions were observed at the inspection. The parameters for administration of anxiolytic/antipsychotic medicines were recorded on the personal medication records. For some patients these medicines are administered infrequently and for one patient, the medicine is administered each day. Staff confirmed that this regular administration had been reported to the prescriber. A record of each administration is maintained. From discussion with the nursing sister, it was concluded that staff are familiar with circumstances when to administer anxiolytic/antipsychotic medicines. Staff have the knowledge to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and are aware that this change may be associated with pain.

Medicines which are prescribed to treat pain are recorded on the personal medication record. Examination of the administration of medicines which are prescribed to treat or prevent pain indicated that with the exception of two controlled drugs, these medicines had been administered as prescribed. This included other regularly prescribed controlled drug patches and also analgesics which are prescribed for administration on a "when required" basis.

From discussion with the registered nurse, it was evident that staff are aware of the signs, symptoms and triggers of pain in patients. Where pain controlling medicines are prescribed, staff are aware that ongoing monitoring is necessary to ensure the pain is well controlled and the patient is comfortable. Care plans in relation to pain management were observed for patients who are prescribed controlled drugs. These are evaluated each month. A pain tool is in use for patients who cannot verbally express pain.

Areas for Improvement

The systems in place to manage any medicine changes should be reviewed. For one patient the audit trail on mirtazapine tablets could not be concluded. The details on the personal medication record and medication administration record did not correlate and it could not be ascertained what the correct dose was or what dose had been administered. An urgent action record was completed at the inspection. The registered person was requested to investigate the observations made in relation to mirtazapine. A written report of the findings and action taken was forwarded to RQIA on 1 May 2015. The action taken was satisfactory.

Although it was acknowledged that there were mostly satisfactory audit outcomes, several discrepancies were observed in the audit trails performed on liquid medicines. These were highlighted at the inspection. The registered person must implement robust monitoring arrangements for liquid medicines to ensure these medicines are administered in strict accordance with the prescriber's instructions. A requirement was made.

Whilst it is good practice to undertake a weekly audit in relation to thickening agents, the accuracy of the audit outcomes should be reviewed, as it was noted that the recent audit information was incorrect. This was discussed with the nursing sister and it was agreed that this would be reviewed with immediate effect.

A few entries on the personal medication records (PMRs) were not up to date and were highlighted at the inspection. Some obsolete PMRs remained with the current PMR. These should be removed and archived. It was agreed that this would be addressed on the day of the inspection. The nursing sister also advised that the PMRs would be rewritten at the earliest opportunity.

The management of controlled drugs must be reviewed. Examination of the records indicated that two controlled drug patches had not been administered on time. One had been delayed for three days and the other patch for one day. These patches are prescribed for administration once each week; however, it could not be confirmed if there were any ill effects to the patients. It was also noted that the day of the administration recorded on the personal medication record had not been updated. The registered person must investigate the management of these two controlled drugs and forward details of the findings to RQIA. A requirement was made. It was acknowledged that a reminder card to facilitate administration had since been developed and is located for ease of reference. On examination of the controlled drug record book, it was noted that incorrect dates had been entered and on a small number of occasions, a second signature on the entry had been omitted. The registered person should closely monitor the record keeping in the controlled record book to ensure the information recorded is accurate. A recommendation was made.

During the inspection, it was noted that several medicine record entries and care plans were difficult to read due to the handwriting. As these records are used as a reference point, the need for legible records was emphasized. A recommendation was made.

In accordance with safe practice, it was agreed that two trained staff would be involved in any future transcribing on PMRs and also any handwritten MARs.

In relation to the management of medicines which are administered on a "when required" basis for distressed reactions, a care plan is not in place. This should be developed for the relevant patients. The reason for and outcome of the medicine administration should be recorded on each occasion. A recommendation was made.

With regard to pain management, the registered person should ensure that where medicines are prescribed for the management of pain on a "when required" basis, this is clearly referenced in a care plan. A recommendation was made.

Number of Requirements:	**2**	**Number of Recommendations:**	**4**

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Diana Pahome (Nursing Sister) as part of the inspection process. The timescales commence from the date of inspection.

The registered manager/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 HPSS (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 to 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 by the registered manager. 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:** Second time **To be Completed by:** **28 May 2015**	The registered manager must ensure that all medicines are administered as prescribed and records of administration are accurately maintained.
	Response by Registered Person(s) Detailing the Actions Taken: All registered nurses who administer medications have had their 'Management of Medication assessment' carried out to ensure they are fully aware of their accountability and responsibility.
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be Completed by:** **28 May 2015**	The registered person must implement robust monitoring arrangements for liquid medicines to ensure these medicines are administered in strict accordance with the prescriber's instructions.
	Response by Registered Person(s) Detailing the Actions Taken: All liquid medicines were measured and interim scripts were ordered to bring the liquids into line. Daily tally sheets have been put in place to prevent a reoccurence. This was discussed at the RN staff meeting on 14.05.15.
Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be Completed by:** **28 May 2015**	The registered person must investigate the observations made in the two controlled drug patches which were administered late; a written report of the findings and action taken must be forwarded to RQIA.
	Response by Registered Person(s) Detailing the Actions Taken: This investigation was carried out by Mr J Coyle, Peripatetic Home Manager and the findings have been E Mailed to Mrs Taylor today 10.06.15
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be Completed by:** **28 May 2015**	It is recommended that the registered person should closely monitor the record keeping in the controlled record book to ensure the details recorded are accurate.
	Response by Registered Person(s) Detailing the Actions Taken: The Registered Manager checks and signs the controlled book in each unit on a weekly basis to maintain the accuracy of the entries. This was discussed at the RN staff meeting on 14.05.15.

Recommendations	
Recommendation 2 **Ref:** Standard 28 **Stated:** First time **To be Completed by:** **28 May 2015**	It is recommended that the registered person should ensure that all handwritten entries on medicine records including care plans are legible.
	Response by Registered Person(s) Detailing the Actions Taken: The Registered Manager carries out spot checks to ensure handwritten entries are legible. All nursing staff informed of the importance of this at the RN staff meeting on 14.05.15
Recommendation 3 **Ref:** Standard 28 **Stated:** First time **To be Completed by:** **28 May 2015**	It is recommended that the registered person should ensure that where medicines are prescribed on a "when required" basis for the treatment of distressed reactions, a care plan is in place and staff record the reason for and the outcome of the administration of the medicine on every occasion.
	Response by Registered Person(s) Detailing the Actions Taken: The need for a care plan regarding medication which is used on a 'when required' basis to help a resident who is distressed, was discussed at the RN meeting. All nurses are fully aware of the need to record the reasons the medication is given on every occasion and also the outcome of the treatment..
Recommendation 4 **Ref:** Standard 28 **Stated:** First time **To be Completed by:** **28 May 2015**	It is recommended that the registered person should ensure that where medicines are prescribed for the management of pain on a "when required" basis, this is clearly referenced in a care plan.
	Response by Registered Person(s) Detailing the Actions Taken: All GP's have been contacted and asked to carry out a medication review for all their residents who are on pain relief 'when required' with a view to obtaining specific directions on the scripts.

Registered Manager Completing QIP	Shirley Martin	**Date Completed**	10.06.15
Registered Person Approving QIP	Dr Claire Royston	**Date Approved**	15.06.15
RQIA Inspector Assessing Response		**Date Approved**	

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

J P Watson
MANAGING DIRECTOR
16/6/15.

The Regulation and Quality Improvement Authority

RQIA Inspector Assessing Response	Judith Taylor	**Date Approved**	18 June 2015