Unannounced Medicines Management Inspection Report
5 October 2017

Antrim Care Home

Type of Service: Nursing Home
Address: 88 Milltown Road, Antrim, BT41 2JJ
Tel no: 028 9442 8717
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 with 53 beds that provides care for patients and residents living with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Hutchinson Homes Ltd **Responsible Individual:** Mrs Janet Montgomery	**Registered Manager:** Mrs Sharon Smyth
Person in charge at the time of inspection: Mrs Sharon Smyth	**Date Manager Registered:** 10 June 2016
Categories of care: Nursing Homes (NH) I – Old age not falling within any other category DE – Dementia PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years TI – Terminally ill Residential (RC) I – Old age not falling within any other category	**Number of registered places:** 53

4.0 Inspection summary

An unannounced inspection took place on 5 October 2017 from 10.05 to 16.20.

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.

Overall, there was evidence of good practice in relation to medicines management; this included training, administration of medicines, record keeping, management of new patient's medicines/ medicines changes and storage of medicines/controlled drugs.

Areas requiring improvement were identified in relation to inhaled medicines, limited shelf-life medicines, external preparations and care planning regarding the management of distressed reactions and pain.

Patients were complimentary regarding the management of their medicines and the care provided in the home.

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	*5

*The total number of areas for improvement includes one which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Sharon Smyth, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 15 June 2017. 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 incidents register: it was ascertained that no medicine related incidents had been reported to RQIA since the last medicines management inspection.

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection we met with three patients, three registered nurses and the registered manager.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

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
- care plans
- training records
- medicines storage temperatures

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 15 June 2017

The most recent inspection of the home was an unannounced care management inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the care inspector at the next inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 28 September 2016

Areas for improvement from the last medicines management inspection		
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 provider should review the disposal of controlled drugs to ensure that they are appropriately denatured prior to disposal.	**Met**
	Action taken as confirmed during the inspection: The disposal of controlled drugs had been reviewed. A separate disposal record book for controlled drugs was in use in some of the units. There was evidence that Schedule 2, Schedule 3 and the majority of Schedule 4 controlled drugs had been denatured prior to disposal. However, in relation to Schedule 4, some records did not clearly state this and	

	was discussed with staff. They confirmed that this would be stated from the day of the inspection onwards and monitored through audit. Given this assurance this area for improvement was assessed as met.	
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time	The registered provider should ensure there is a robust system in place for the management of limited shelf-life medicines.	**Not met**
	Action taken as confirmed during the inspection: There was limited evidence to indicate that this area of medicines management had been reviewed. Three medicines (two eye preparations and one insulin pen) were removed for disposal as the expiry date had been reached or the expiry date was not known. **This area for improvement has been stated for a second time.**	
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time	The registered provider should review the auditing process for medicines to ensure that staff record the date of opening on all medicines.	**Met**
	Action taken as confirmed during the inspection: The date of opening was routinely recorded on medicines.	

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. Refresher training in medicines management was provided in the last year.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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; and to manage changes to prescribed medicines.

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

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 some other controlled drugs which is good practice. It was advised that a monitoring system should also be considered for controlled drugs which were stored on the medicine trolley e.g. lorazepam. Advice was given. The registered manager agreed that these would be commenced.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. In accordance with recognised good practice, it was suggested that a separate insulin administration record should be developed and implemented.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Since the last medicines management inspection, the storage areas for medicines had been reviewed and refurbished. Three treatment rooms were used to store medicines; they were clean, tidy and well organised. Patients' medicines were clearly segregated and stored safely and securely and in accordance with the manufacturer's instructions. Medicine refrigerators and oxygen equipment were checked regularly.

The management of medicines with a limited shelf-life once opened should be reviewed. (See also Section 6.2.) Three medicines were removed for disposal and replacement. This issue had been raised before and the area for improvement was stated for a second time. The need to ensure that these medicines are included in the auditing process was discussed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessment, the management of medicines on admission/discharge and controlled drugs.

Areas for improvement

An area for improvement under standards has been stated for a second time in relation to the management of limited shelf-life medicines.

	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.

With the exception of inhaled medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. An area for improvement was identified.

There were satisfactory arrangements in place to alert staff of when time critical medicines must be administered, such as early morning medicines, medicines for Parkinson's and also medicines which were prescribed at weekly or three monthly intervals.

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. Following discussion with staff, it was evident that they knew knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour; however, it was not clear if they were aware that this change may be associated with pain. This was discussed, particularly, in relation to patients who could not communicate pain. The reason for the administration was recorded and this is good practice; however, the outcome should also be recorded. A review of a sample of patient's care files indicated that a care plan was not maintained for each patient prescribed these medicines. An area for improvement was identified.

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 some of the patients could verbalise their pain, and a pain assessment tool was noted in some patients' care files. In the dementia unit, there was no evidence that a pain assessment tool was in use or that pain management was referenced in the patients' care plans. Whilst it was acknowledged that the staff stated they were familiar with the patients and how they would express pain, this should be recorded. An area for improvement was identified.

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.

When antibiotics were prescribed, a care plan was maintained. This is good practice.

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. They confirmed that most patients were generally compliant with their medicine regimes.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the maintenance of separate administration records for transdermal patches, injections, warfarin and antibiotics; and double signatures for the writing and updating of personal medication records and administration of warfarin.

However, an area for improvement was identified in relation to external preparations. The records should clearly state if the external preparation is prescribed for regular use or 'when required' use; the date of discontinuation must be recorded on the personal medication record; and records of administration must be fully maintained. It was noted that these preparations were included in the audit process; however, this had not been effective in identifying the necessary improvement.

Protocols for 'when required' medicines had been developed and implemented for some patients. These are recognised as good practice and it was suggested that they were used in each of the three units in the home.

Following discussion with the registered manager 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.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the administration of medicines and the standard of record keeping. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

The administration of inhaled medicines should be closely monitored to ensure that these are administered as prescribed.

The management of distressed reactions should be reviewed to ensure that a care plan is maintained for all patients prescribed medicines on a 'when required' basis; this should detail the interventions necessary to assist the patient and when the medicine should be administered.

The management of pain should be reviewed to ensure that:

- a pain assessment is completed for new patients
- a suitable pain assessment tool is used for patients who are unable to communicate pain
- the patient's pain management is detailed in a care plan
- staff are aware that distressed reactions may occur as the patient is in pain.

The management of external preparations should be closely monitored to ensure records are fully and accurately maintained.

	Regulations	Standards
Total number of areas for improvement	0	4

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 observed during the inspection. Medicines were administered to patients in the dining room or in their room. The registered nurse administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to swallow each medicine. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

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. It was clear from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes.

The patients spoken to at the inspection, advised that they had no concerns in relation to the management of their medicines, they preferred the registered nurses to administer their medicines and their requests for medicines prescribed on a "when required" basis was adhered to e.g. pain relief. They were complimentary regarding staff and management. Comments included:

"The staff are good to you here, very good."
"I would recommend this place, its A1."
"The food is good."
"The staff will help me if I need anything."

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.

We met with staff throughout the inspection. Comments included:

"I like working here."
"We can get help and support."
"I have no concerns, the care is good."
"It's a good team."

Of the questionnaires which were left in the home to facilitate feedback from patients, their representatives and staff, two were returned from patients, one from a patient's representative and four from staff. The responses indicated that they were very satisfied/satisfied with all aspects of the care in relation to the management of medicines.

One relative questionnaire included the following statement:

"My xxx is in the process of moving to residential care and as a family we would love to find a place for xxx like here. The ambiance, friendliness of all the staff here is really good. xxx tells us every day how good the staff are to xxx." (xxx replaces the patient's identity.)

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the staff listening to and taking account of the views of patients.

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.

Written policies and procedures for the management of medicines were in place. These were currently being updated. The registered manager advised of the processes in place to ensure that staff were kept up to date of any changes.

There were systems in place to manage any medicine related incidents. Staff confirmed that they knew how to identify and report incidents and advised of how incidents were shared with them to inform learning and change of practice, if necessary. 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 auditing arrangement for medicines was reviewed. A range of medicine audits were completed by the registered nurses and management, on a weekly and monthly basis. In addition an audit was completed by the community pharmacist throughout the year. A review of the audit records indicated that largely satisfactory outcomes had been achieved. Staff advised of the procedures followed when any areas were identified for improvement and provided details of where practice had changed. At the end of the inspection, the registered manager provided assurances that the auditing processes would be further developed, to ensure that they were effective.

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

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that management were open and approachable and willing to listen. They also stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

Not all of the areas for improvement made at the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

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

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Sharon Smyth, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP to Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 30 **Stated:** Second time **To be completed by:** 5 November 2017	The registered provider should ensure there is a robust system in place for the management of limited shelf-life medicines. Ref: 6.2 & 6.4
	Response by registered person detailing the actions taken: The timing of the managers monthly audit will be changed to the beginning of the 4 weekly cycle to ensure that shelf-life limited medicines are managed more robustly
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 5 November 2017	The registered person shall closely monitor the administration of inhaled medicines to ensure that these are administered as prescribed. Ref: 6.5
	Response by registered person detailing the actions taken: The admisitration of inhaled medicines will be monitored and non-compliance managed more closely
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 30 October 2017	The registered person shall review the management of distressed reactions to ensure that a detailed care plan is in place for each patient and the outcome of administration is recorded. Ref: 6.5
	Response by registered person detailing the actions taken: In-house training has been provided on distressed reactions for all staff and individual care plans have been completed, outlining when medication is to be given and the effect of the medication recorded. This will also be reviewed on a monthly basis.

Area for improvement 4 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 30 October 2017	The registered person shall review the management of pain to ensure that pain assessments are completed and a record maintained; pain management is referenced in a care plan and further guidance is provided for pain management in dementia. Ref: 6.5
	Response by registered person detailing the actions taken: Relevant pain assessments have been completed; separate care plans and guidance documented for all residents. This will be reviewed monthly.
Area for improvement 5 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 30 October 2017	The registered person shall review the management of external preparations to ensure robust systems are in place. Ref: 6.5
	Response by registered person detailing the actions taken: Additional training will be provided for all new staff and a separate audit put in place for external preparations.

Please ensure this document is completed in full and returned to Web Portal

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