Unannounced Medicines Management Inspection Report
7 July 2016

Ardmaine Care Home

Type of Service: Nursing Home
Address: 8 Fullerton Road, Newry, BT34 2AY
Tel No: 028 3026 2075
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Ardmaine Care Home took place on 7 July 2016 from 09:50 to 14:55.

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 promoted the delivery of positive outcomes for patients. Staff were trained and competent and there were robust processes for the management of medicines changes and management of high risk medicines. The standard of maintenance of the controlled drug record book should be closely monitored. One recommendation has been made.

Is care effective?

There was evidence that the management of medicines supported the delivery of effective care for patients. There were systems in place to ensure that the patients were administered their medicines as prescribed. Robust arrangements were in place for the management of pain. No requirements or recommendations have been made.

Is care compassionate?

There was evidence that the management of medicines supported the delivery of compassionate care. Staff interactions with patients were observed to be compassionate, caring and timely. No requirements or recommendations have been made.

Is the service well led?

There was evidence that the service was well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place. There were robust systems to manage and share the learning from medicine related incidents and areas identified within the audit process. No requirements or recommendations have been 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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015.

1.1 Inspection outcome

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Ann Begley, 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 inspection on 10 March 2016.

2.0 Service details

Registered organisation/registered provider: Four Seasons (Bamford) Ltd Dr Maureen Claire Royston	**Registered manager:** Mrs Ann Begley
Person in charge of the home at the time of inspection: Mrs Ann Begley	**Date manager registered:** 24 January 2013
Categories of care: NH-MP, NH-I, NH-DE	**Number of registered places:** 65

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 one patient, two care assistants, four registered nurses and the registered manager.

The following records were examined:

- 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 10 March 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 specialist inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 9 April 2014

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The date of administration must be accurately recorded for all medicines.	**Met**
	Action taken as confirmed during the inspection: This requirement referred specifically to hand-written medication administration records. The date of administration was observed to be accurately recorded.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 37 **Stated:** Second time	A list of the names, initials and signatures of those care assistants deemed competent to administer external preparations and thickening agents should be maintained.	**Met**
	Action taken as confirmed during the inspection: An up to date list was in place.	

Recommendation 2 **Ref:** Standard 37 **Stated:** First time	The registered manager should audit the administration of inhaled medicines.	**Met**
	Action taken as confirmed during the inspection: The date of opening of supplies of inhaled medicines in use had been recorded and running stock balances were being maintained where possible.	
Recommendation 3 **Ref:** Standard 37 **Stated:** First time	The registered manager should review and revise the recording systems for the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: Parameters for administration were recorded on the personal medication records. Administration was recorded on the medication administration record sheets. Individual protocol sheets and care plans were observed to be in place. The reason and outcome of administration had been recorded.	

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 supervision and annual appraisal. Competency assessments were completed annually. Care staff had received training on the management of thickening agents and were currently receiving training on the management of external preparations following a recent change to the home's policy and procedures. Registered nurses advised that they would like to receive update training on the management and administration of rectal diazepam; the registered manager confirmed that this would be arranged.

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 and handwritten entries on medication administration 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.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book; however, some discrepancies in the records were observed. These had not been identified by the registered nurses at their end of shift handovers. The registered manager confirmed via email that each discrepancy which had been highlighted was being investigated. The registered manager also confirmed that new controlled drug record books were due to be delivered by the community pharmacist and advised that each registered nurse would receive supervision with regard to record keeping for controlled drugs. The registered manager should closely monitor the standard of maintenance of the controlled drug record book. A recommendation was made.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged.

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, tidy and well organised. 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.

Areas for improvement

The registered manager should closely monitor the standard of maintenance of the controlled drug record book. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

The sample of medicines examined had been administered in accordance with the prescriber's instructions. 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 weekly, monthly or three monthly medicines were due.

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. Care plans were in place. The reason for and outcome of administration were recorded on most occasions.

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 when patients could not verbalise their pain, a pain tool was used. Care plans were maintained. Staff also advised that a pain assessment is completed as part of the admission process.

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. Registered nurses recorded administration on the medication administration records and care assistants recorded administration in the daily food booklets.

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.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included "when required" protocol sheets for analgesics, laxatives and medicines for use in distressed reactions, alerts for patients with similar names and additional recording sheets for transdermal patches.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines and inhaled medicines, weekly audits on external medicines and thickening agents, monthly management audits and a quarterly advice visit from the community pharmacist.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas for improvement

No areas for improvement were identified during the inspection.

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

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.

Patient comments included:
"Staff are very friendly."
"I can ask for pain relief if I'm sore but I don't like to take too many tablets."

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. The activity therapist was sitting with a group of patients at breakfast making plans for the rest of the day.

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 available in the treatment rooms. They had been updated recently. 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. Medicine related incidents, reported since the last medicines management inspection, were discussed. There was evidence of the action taken and learning implemented following incidents.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice. Action plans were developed and implemented following the registered manager's monthly audits. As detailed in Section 4.3 the audits should include records for controlled drugs.

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. The registered nurses were knowledgeable with regards to each patients needs and were very engaged in the inspection process as they wanted to drive improvement.

Staff confirmed that any concerns in relation to medicines management were raised with management who were supportive of implementing the required improvements.

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 this QIP were discussed with Mrs Ann Begley, 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 taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to pharmacists@rqia.org.uk for review 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 31 **Stated:** First time **To be completed by:** 8 July 2016	The registered provider should closely monitor the standard of maintenance of the controlled drug record book.
	Response by registered provider detailing the actions taken: Following the Inspection 2 New Controlled Drug Books have been put in place and the layout has been changed as advised by Helen Daly. The Home Manager or Deputy Manager check the books on a weekly basis to ensure the correct system is being followed; stock control is correct and recording is appropriate. A revised Controlled Drugs Supervision is now in place and has commenced with Nursing Staff due for completion no later than the 04/09/2016.

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

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