Unannounced Medicines Management Inspection Report
9 August 2016

Cairnhill

Type of Service: Nursing Home
Address: 39 Rathfriland Road, Newry, BT34 1JZ
Tel No: 028 3026 8112
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Cairnhill took place on 9 August 2016 from 09:30 to 11:50.

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?

The management of medicines supported the delivery of safe care. Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. No areas for improvement were identified.

Is care effective?

The management of medicines mostly supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. A requirement was made relating to the accurate maintenance of the medicine administration records and a recommendation was made relating to the review of the arrangements for recording thickening agents.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely. No areas for improvement were identified.

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. No areas for improvement were identified.

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. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

1.1 Inspection outcome

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

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Leah Hughes, Senior Nurse and Ms Lisa Austin, the registered manager of another nursing home owned by the organisation, 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 previous QIP there were no further actions required to be taken following the last inspection on 29 June 2016.

2.0 Service details

Registered organisation/registered provider: Cairnhill Home 'A' Ltd/ Mr Charles Anthony Digney	**Registered manager:** Mr James Digney
Person in charge of the home at the time of inspection: Ms Leah Hughes (Senior Nurse)	**Date manager registered:** 1 April 2005'.
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 22

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home

Prior to the inspection, it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

A poster indicating that the inspection was taking place was displayed on the front door of the home. The poster invited visitors/ relatives to speak with the inspector. No-one availed of this opportunity.

During the inspection the inspector met with the senior nurse and the registered manager of another nursing home owned by the organisation.

The following records were 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 29 June 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.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 12 September 2013

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 32 **Stated:** First time	The temperature of the medicines storage room should be monitored daily in order to ensure it is maintained at or below 25°C.	**Met**
	Action taken as confirmed during the inspection: The temperature of the medicines storage room had been monitored daily.	
Recommendation 2 **Ref**: Standard 32 **Stated:** First time	The overstock oxygen cylinders should be chained to the wall.	**Met**
	Action taken as confirmed during the inspection: The oxygen cylinder was stored safely.	

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

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 medicine 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.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. 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.

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. Medicine refrigerators and oxygen equipment were checked at regular intervals. Insulin pens were not dated when first used; the nurse manager gave an assurance that this would be rectified without delay.

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 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 fortnightly 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. The medicine was infrequently used. A care plan was maintained.

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. They advised that pain was assessed on an ongoing basis. Staff also advised that most of the patients could verbalise any pain, and a pain tool was used as needed.

Care plans and speech and language assessment reports were in place for patients with swallowing difficulties. For those patients prescribed a thickening agent, this was recorded on their personal medication record; however, details of the fluid consistency were not included. Administrations of thickening agents were not recorded. A recommendation was made.

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.

An improvement was needed in the maintenance of the medicine administration records. Eleven of the patients had been administered their morning medication; however, their medicine administration records had not been completed. For one patient, the administrations of one medicine had not been recorded for 23 days. A requirement was made.

Practices for the management of medicines were audited throughout the month by the staff and management.

Following discussion with the senior nurse, it was evident that there were good working relationships with other healthcare workers, including the community pharmacist and prescribers.

Areas for improvement

The arrangements for recording thickening agents should be reviewed. A recommendation was made.

The medicine administration records must be accurately maintained. A requirement was made.

Number of requirements	**1**	**Number of recommendations**	**1**

4.5 Is care compassionate?

The administration of medicines to one patient was observed during the inspection. The nurse administering the medicines spoke to the patient in a kind and caring manner. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff and patient interaction and communication demonstrated that patients were treated courteously, with dignity and respect. Good relationships were evident.

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. Following discussion with staff, it was evident that they were knowledgeable of the policies and procedures and that any updates were highlighted to them.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents.

A review of the audit records indicated that satisfactory outcomes had been achieved.

Following discussion with the senior nurse, it was evident that staff had a good knowledge of their roles and responsibilities in relation to medicines management.

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

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Leah Hughes, Senior Nurse and Ms Lisa Austin, the registered manager of another nursing home owned by the organisation, 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 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	
Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 8 September 2016	The registered provider must ensure that the medicine administration records are accurately maintained.
	Response by registered provider detailing the actions taken: Reinforcement given to staff re accurate recording of medicine administration, and same will be addressed at forthcoming administration of medication training in October/November.
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 8 September 2016	The registered provider should ensure that the arrangements for recording thickening agents are reviewed.
	Response by registered provider detailing the actions taken: The recording of thickening agents has been reviewed.

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

The Regulation and Quality Improvement Authority

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