Unannounced Medicines Management Inspection Report
16 December 2016

Chestnut Lodge

Type of Service: Nursing Home
Address: 47 Carrickaness Road, Benburb, Dungannon, BT71 7NH
Tel no: 028 3754 8706
Inspector: Frances Gault

1.0 Summary

An unannounced inspection of Chestnut Lodge took place on 16 December 2016 from 10:00 to 13:15.

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 positive outcomes for patients. 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. There were no areas of improvement identified.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. One area of improvement was identified in relation to record keeping and a recommendation was made.

An area for improvement continues to be identified and must be addressed to ensure that the management of medicines supports the delivery of effective care. The management of medicines prescribed for distressed reactions still requires to be reviewed. There was little evidence of care plans in place and some of the medicines were being administered regularly.

To ensure that the management of medicines complies with legislative requirement and standards, the recommendation previously made was stated for a second time.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for patients. There were no areas of improvement 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. There were no areas of improvement 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. RQIA will continue to monitor any

recommendations made under the 2008 standards until compliance is achieved. Please also refer to section 4.2 and 5.0 of this report.

For the purposes of this report, the term 'patients' will be used to described those living in the home which provides both nursing and residential care.

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 Mr Paul Gildernew, 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 most recent inspection on 23 June 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare Dr. Maureen Claire Royston	**Registered manager:** Mr Paul Gildernew
Person in charge of the home at the time of inspection: Mr Paul Gildernew	**Date manager registered:** 17 July 2013
Categories of care: RC-MP(E), NH-PH, RC-I, RC-MP, NH-I, NH-DE Maximum of 20 patients in NH-DE, 17 patients in NH-I, and 2 patients in NH-PH. One regular respite in RC-MP and the home may also provide care on a day basis to 2 persons.	**Number of registered places:** 40

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.

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

We met with three patients, one care staff, two registered nurses and the registered manager.

Twenty-eight questionnaires were issued to staff, patients, relatives/ patients' representatives with a request that these were completed and returned within one week for the inspection.

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
- care plans
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 23 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 specialist inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection 24 February 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should review the management of medicines prescribed for distressed reactions to ensure that all of the relevant records are maintained.	**Not Met**
	Action taken as confirmed during the inspection: While the registered manager had confirmed in the returned QIP that the management of these medicines had been reviewed, we found little evidence of care plans in place to direct the care of patients with distressed reactions. It was also evidenced that in some instances medicines prescribed "when required" were being administered regularly. In one instance the nurse advised that this dosage regime was due to be reviewed by the consultant. This recommendation will be restated.	
Recommendation 2 **Ref**: Standard 38 **Stated:** First time	The registered manager should monitor the completion of the record of disposed medicines to ensure that it is signed by two nurses.	**Met**
	Action taken as confirmed during the inspection: The evidence seen during the inspection was that these entries were usually verified by two nurses.	

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. The registered manager advised that the relevant e-learning programme had been completed by almost all nurses. The most recent training was in relation to the use of medicines in palliative care and the management of dysphagia.

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.

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 the other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. 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

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

The majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. The few anomalies found were discussed with staff and it was agreed attention would be given to liquid and inhaled medicines in forthcoming audits. There were arrangements in place to alert staff of when doses of weekly medicines were due.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, specific 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 reason for and the outcome of administration were not always recorded. There was little evidence of care plans in place. The recommendation, previously made, in relation to distressed reactions is stated for the second time.

The medicine administration records reviewed evidenced that on a number of occasions these medicines were being administered regularly instead of "when required". It was agreed that this would be discussed with the prescriber.

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 most of the patients could verbalise any pain, and a pain tool was used as needed. A care plan was maintained.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record and but did not always include details of the fluid consistency. It was agreed with the registered nurses that this oversight would be addressed. Each administration was recorded and care plans and speech and language assessment reports were in place. Care staff knew their role in the administration process and their responsibility with regard to recording.

Medicine records were well maintained and facilitated the audit process.

Practices for the management of medicines were audited by the staff and management. In addition, a quarterly audit was completed by 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 the specific healthcare needs of the patients.

Areas for improvement

The registered manager should review the management of medicines prescribed for distressed reactions to ensure that all of the relevant records are maintained. The recommendation previously made was stated for the second time.

Number of requirements	0	**Number of recommendations**	1

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.

Lunch was being served during the inspection. One patient advised that his lunch was "splendid". 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.

Twenty eight questionnaires were left in the home to facilitate feedback from patients, staff and relatives. Seventeen were returned. The responses were recorded as 'satisfied' or 'very satisfied' with the management of medicines in the home.

Comments from relatives included:

- "The care given to Mum at Chestnut Lodge is 'first class'. The staff work extremely hard to ensure Mum is comfortable and free from pain at all times."
- "Staff are very approachable and treat us, as a family, with utmost respect and kindness."
- "Completely satisfied with all aspects of care given to Mum at Chestnut Lodge".

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. These were not examined during the inspection. 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. There have been no medicine incidents reported since the last medicines management inspection.

The registered manager advised that the internal audits evidenced satisfactory outcomes as did those of the community pharmacist.

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.

One of the two recommendations made at the last medicines management inspection had not been addressed effectively (see sections 4.2 and 4.3) and was restated. To ensure that this is fully addressed and the improvement sustained, it is suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Staff confirmed that any concerns in relation to medicines management were raised with management. One member of staff advised that he was “very approachable”.

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 the QIP were discussed with Mr Paul Gildernew, 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 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 to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to RQIA's web portal for assessment 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 37	The registered manager should review the management of medicines prescribed for distressed reactions to ensure that all of the relevant records are maintained.
Stated: Second time **To be completed by:** 31 January 2017	**Response by registered provider detailing the actions taken:** All residents that require medication to manager distressed reactions will have a full plan of care in place and associated risk assessments. Following a distressed reaction and administration of appropriate medication,the nurse will assess and record the effectivness of the medication given. This will be monitored through the internal QOL audit system which is carried out daily and on a monthly basis via the Managers Monthly medication audit which includes the use of PRN medication and the associated follow up documentation.

***Please ensure this document is completed in full and returned to RQIA's Web Portal ***

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