

Unannounced Medicines Management Inspection Report 19 December 2016



Copperfields

Type of Service: Nursing Home
Address: 1-3 Moore Street, Aughnacloy, BT69 6AX
Tel no: 028 8555 7922
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Copperfields took place on 19 December 2016 from 11.15 to 14.10.

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. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. 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. There were no areas of improvement identified.

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. Patients consulted with confirmed that they were administered their medicines appropriately. 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.

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

1.1 Inspection outcome

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Cherith McKeown, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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 2 June 2016.

2.0 Service details

Registered organisation/registered person: Edward Enterprises NI Ltd Mr William Henry Hume Edwards	Registered manager: Mrs Cherith McKeown
Person in charge of the home at the time of inspection: Mrs Cherith McKeown	Date manager registered: 1 April 2005
Categories of care: NH-LD, NH-LD(E), RC-I, NH-DE, NH-I	Number of registered places: 32

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

We met with one patient, two care staff, one registered nurse and the registered manager.

A number of questionnaires were issued to patients, relatives/patients' representatives and staff, with a request that they were returned within one week from the date of the inspection.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- medicine audits
- care plans
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 2 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 5 February 2015

There were no requirements or recommendations made as a result of the last medicines management inspection.

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. The registered manager advised that update training on medicines management has been requested from the community pharmacist.

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 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.

The controlled drug record book was not in use as controlled drugs in Schedule 2 were not prescribed. Checks were performed on controlled drugs which require safe custody and some Schedule 4 Part (1) controlled drugs at the end of each shift.

Mostly satisfactory arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged. The registered manager was reminded that insulin pens should be labelled and that the abbreviation "i.u." should not be used. It was acknowledged that this was an oversight and that it would be discussed with all registered nurses for corrective action.

Discontinued or expired medicines were disposed of appropriately. The registered manager confirmed that 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. It was agreed that the temperature of the treatment room would be recorded each day.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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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. Care plans were in place. 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 recorded.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were maintained. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Pain assessment tools were used for patients who could not verbalise their pain. The registered manager confirmed that a pain assessment was completed as part of the admission process.

The management of swallowing difficulty was examined. Care plans and speech and language assessment reports were in place. When prescribed, thickening agents were recorded on the personal medication records and included details of the fluid consistency. Records of administration were maintained by both registered nurses and care staff.

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. The good standard of record keeping was acknowledged.

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

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
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4.5 Is care compassionate?

The registered manager confirmed that 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.

We spoke with one patient who advised that she was happy with how her medicines were managed. She confirmed that additional pain relief could be requested and that the registered nurses and staff were “great”.

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.

As part of the inspection process 15 questionnaires were issued to patients, relatives/patients’ representatives and staff, with a request that they were returned within one week from the date of the inspection. Twelve questionnaires were completed and returned. The responses were positive and these were recorded as “very satisfied” with regard to the management of medicines in the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. Management advised that these were reviewed regularly. 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.

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.

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.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff at handovers.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.



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