The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report
12 May 2016

Corkhill Care Centre

27 Coolmaghery Road, Donaghmore, Dungannon, BT70 3HJ
Tel No: 028 8776 7362
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Corkhill Care Centre took place on 12 May 2016 from 11:00 to 16:00.

The inspection sought to assess progress with any issues raised 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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern though some minor areas for improvement were discussed and appropriate corrective action agreed. As no requirements or recommendations were made a quality improvement plan (QIP) was not issued.

Is care safe?
No requirements or recommendations were made.

Is care effective?
No requirements or recommendations were made.

Is care compassionate?
No requirements or recommendations were made.

Is the service well led?
No requirements or recommendations were 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.

For the purposes of this report, the term "patients" will be used to describe those living in Corkhill Care Centre 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 Ms Alison McCulla, Nurse in Charge, and Ms Hayley Jordan, Operations 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

There were no further actions required to be taken following the most recent inspection on 11 November 2015.

2.0 Service details

Registered organisation/registered person: Mr Thomas Potts Mrs Margaret Potts	**Registered manager:** See box below
Person in charge of the home at the time of inspection: Ms Alison McCulla	**Date manager registered:** Ms Veronica McElmurry – Registration pending
Categories of care: NH-I, NH-PH, NH-DE, RC-I, RC-PH, RC-DE, NH-LD, NH-LD(E)	**Number of registered places:** 48

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 two patients, two registered nurses, the operations manager and two care assistants.

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 11 November 2015

The most recent inspection of the home was an unannounced care inspection. No requirements or recommendations were made.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 4 November 2013

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 senior carers for the management and administration of medicines. Training on the administration of thickening agents and emollients had been provided for care staff. The impact of training was monitored through the audit process, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management had been provided by the community pharmacist in April 2016.

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 up to date and reflected the prescribers' most recent directions; they were reprinted and signed by two registered nurses/senior carers at each update. Handwritten entries on medication administration records were also updated by two registered nurses/senior carers. Obsolete personal medication records had not been cancelled and archived in the nursing suite; the operations manager and nurse in charge advised that this would be actioned before the end of the day.

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 controlled drug record books. Checks were performed on controlled drugs which require safe custody at the end of each shift.

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

Appropriate arrangements were in place for administering medicines in disguised form.

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 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. Detailed care plans were in place in the residential suite and the reason and outcome of each administration had been recorded. This system was not in place in the nursing suite. The operations manager had commenced writing the care plans and recording sheets were put in place before we left the home. It was agreed that this would be highlighted to all registered nurses for immediate action and hence a recommendation was not made.

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. 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 each administration on the medication administration records. Care assistants were no longer recording each administration. The operations manager advised that the daily nutrition chart would be amended to include the required consistency level and that care assistants would be reminded to record each administration. It was agreed that this would be closely monitored by the operations manager.

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.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for medicines which were not contained within the blister pack system. Audits were being carried out on the medicines for one patient in each suite each night. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the nurse in charge and staff, it was evident that when applicable, healthcare professionals are contacted in response to patient need in relation to medicines management.

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. The two patients we spoke to advised that they were glad that their medicines were being managed by the registered nurses. They confirmed that they were able to request additional pain relief if necessary.

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.

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. 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. Medicine related incidents, reported since the last medicines management inspection, were discussed. There was evidence of the action taken and learning implemented following incidents.

The operations manager and nurse in charge advised that largely satisfactory outcomes had been achieved in the home's audits and, that 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 nurse in charge, senior carer and care assistant, 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 to all staff.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

No requirements or recommendations resulted from this inspection.

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 person/manager from their responsibility for maintaining compliance with the regulations and standards.

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