Unannounced Medicines Management Inspection Report
14 April 2017

Corkhill Care Centre

Type of Service: Nursing Home
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 14 April 2017 from 10.10 to 14.15.

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. No requirements or recommendations were made.

Is care effective?

Most areas for the management of medicines supported the delivery of effective care. The majority of medicines were administered as prescribed however one area for improvement in relation to the management of inhaled medicines was identified and a requirement was made.

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 for 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. 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 described 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	1	0

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Shona McKeown, 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 2 November 2016.

2.0 Service details

Registered organisation/registered person: Mr Gary George Watt	**Registered manager:** Mrs Shona McKeown
Person in charge of the home at the time of inspection: Mrs Shona McKeown	**Date manager registered:** 4 April 2017
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; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

We met with two patients, one senior carer, one registered nurse and the registered manager.

A sample of the following records was 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
- training records
- medicines storage temperatures

Fifteen 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.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 2 November 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 12 May 2016

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 most recent training had been provided by the community pharmacist in March 2016. The registered manager advised that refresher training on medicines management with a focus on inhaler devices has been requested. Competency assessments were completed annually.

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. 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.

Discontinued or expired medicines were disposed of appropriately. Staff confirmed that discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. It was agreed that two registered nurses would be involved in the disposal of medicines and that it would be clearly recorded that controlled drugs were denatured.

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 daily. It was agreed that spacer devices would be regularly cleaned or replaced.

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?

With the exception of some inhaled medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. We observed significant audits discrepancies in the administration of some inhaled medicines. The registered provider must closely monitor the administration of inhaled medicines to ensure that they are being administered as prescribed. A requirement was made.

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 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. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Care plans were in place and pain assessment tools were used for patients who could not verbalise their pain.

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. Each administration was recorded.

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. These included separate 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. 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 medication related issues.

Areas for improvement

The registered provider must closely monitor the administration of inhaled medicines to ensure that they are being administered as prescribed. A requirement was made.

Number of requirements	1	Number of recommendations	0

4.5 Is care compassionate?

We observed the administration of medicines to one patient. It was completed in a caring manner, the patient was given time to take their medicines and medicines were administered as discreetly as possible.

We spoke with two patients who advised that they were very happy with the care provided in the home.

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/ representatives and staff, with a request that they were returned within one week from the date of the inspection. Two patients completed and returned the questionnaires; their 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

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. Management advised that these were currently being reviewed. Following discussion with staff it was evident that they were familiar with the policies and procedures.

The registered manager and register nurse confirmed that there were robust arrangements in place for the management of medicine related incidents. Staff were aware that incidents may need to be reported to the safeguarding lead.

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. As discussed in Section 4.4 the audit process should be further developed to include inhaled medicines.

Following discussion with the registered manager, registered nurse 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 either individually or via team meetings.

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 Mrs Shona McKeown, 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 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 via 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

Statutory requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 15 May 2017	The registered provider must closely monitor the administration of inhaled medicines to ensure that they are being administered as prescribed. **Response by registered provider detailing the actions taken:** Nurse Manager will monitor and action as above. All relevant staff are aware of the audit findings and requirement to be vigilant to ensure doses are administered. McKeevers Chemist are providing training re: inlalers 24/05/17 on site and staff are aware that they are expected to attend. Shona McKeown (Nurse Manager)

Please ensure this document is completed in full and returned via web portal

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