Unannounced Medicines Management Inspection Report
1 August 2016

Kilbroney House

Type of Service: Nursing Home
Address: 83 Kilbroney Road, Rostrevor, BT34 3BL
Tel No: 028 4173 8600
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Kilbroney House took place on 1 August 2016 from 09:30 to 12:45.

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. Staffs 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 generally supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. However, recommendations were made relating to medication prescribed for administration on a "when required" basis for the management of distressed reactions, medication prescribed for pain management and the recording of 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. Patients consulted with confirmed that they were administered their medicines appropriately. 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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Pauline Campbell, Nurse 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 previous QIP there were no further actions required to be taken following the last inspection on 16 May 2016.

2.0 Service details

Registered organisation/registered provider: Mrs Jacqueline Ann Campbell	**Registered manager:** Mrs Jacqueline Ann Campbell
Person in charge of the home at the time of inspection: Mrs Pauline Campbell (Nurse Manager)	**Date manager registered:** 1 April 2005
Categories of care: NH-PH, NH-PH(E), NH-MP, NH-MP(E), NH-DE, NH-I	**Number of registered places:** 19

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 a front window 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 two patients the nurse manager and two registered nurses.

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 16 May 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 9 November 2015

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

4.3 Is care safe?

Medicines were managed by staff who had 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.

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

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 routinely 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 weekly and fortnightly medicines were due.

The records for two patients who had medication prescribed for administration on a "when required" basis for the management of distressed reactions were examined. The dosage instructions were recorded on the personal medication record and the reason for and outcome of administration were recorded. However, the care plans did not specify the circumstances when the medication was to be used; a recommendation was made.

The records for two patients who had medication prescribed to manage pain were examined. The records indicated that the medicines 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 also advised that a pain assessment was completed as part of the admission process. However, for one patient who was unable to express pain, a care plan was not maintained and there was no pain tool; a recommendation was made.

The management of swallowing difficulty was examined for one patient. A care plan and speech and language assessment report were in place. However, the prescribed thickening agent was not recorded on the patient's personal medication record and its administrations were not recorded; a recommendation was made.

Staff confirmed that compliance with prescribed medicine regimes was monitored and omissions or refusals likely to have an adverse effect on the patient's health were reported to the prescriber.

Medicine records were generally well maintained and facilitated the audit process. A nutritional feed was not recorded on one patient's personal medication record; the nurse manager gave an assurance that this matter would be rectified without delay.

Practices for the management of medicines were audited throughout the month by the staff and management. The dates and times of opening of the medicine containers were mostly recorded in order to facilitate audit; however, the attention of the nurse manager was drawn to several boxed medicines that did not have this information recorded.

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

Areas for improvement

When a patient is prescribed medication for administration on a "when required" basis for the management of distressed reactions, the care plan should detail the circumstances when it is to be used. A recommendation was made.

Pain management care plans should be in place and pain assessment tools should be in use, where appropriate. A recommendation was made.

The prescribing and administration of thickening agents should be recorded. A recommendation was made.

Number of requirements	0	Number of recommendations	3

4.5 Is care compassionate?

The morning medication round had been completed before the commencement of the inspection. No medicines were observed to be administered to patients during the inspection.

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.

The patients spoken to advised that they had no concerns in relation to the management of their medicines and were very satisfied with the care they received.

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 nurse manager and registered nurses, 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 Mrs Pauline Campbell, Nurse 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 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	
Recommendations	
Recommendation 1 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 31 August 2016	The registered provider should ensure that, when a patient is prescribed medication for administration on a “when required” basis for the management of distressed reactions, the care plan specifies the circumstances when it is to be used.
	Response by registered provider detailing the actions taken: has been brought to the attention of all named nurses to ensure approprtiate care plans and regular reviews of same are done for all residents this applies to. These will be audited regularly by management
Recommendation 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 31 August 2016	The registered provider should ensure that pain management care plans are in place and pain assessment tools are in use, where appropriate.
	Response by registered provider detailing the actions taken: pain management care plans and assessment tools have now been put in place for appropreiate residents.
Recommendation 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 31 August 2016	The registered provider should ensure that the prescribing and administration of thickening agents are recorded.
	Response by registered provider detailing the actions taken: The prescribing of thickening agents and administration of same is now recorded on the main medication kardex.

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

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