Unannounced Medicines Management Inspection Report
1 June 2017

Kilbroney House

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

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 19 beds that provides care for patients of old age not falling within any other category, patients with dementia, patients with mental health disorder excluding learning disability or dementia and patients with physical disability other than sensory impairment.

3.0 Service details

Organisation/Registered Provider: Ms Jaqueline Ann Campbell	**Registered Manager:** Ms Jaqueline Ann Campbell
Person in charge at the time of inspection: Mrs Pauline Campbell (Nurse Manager)	**Date manager registered:** 1 April 2005
Categories of care: Nursing Care (NC) I - Old age not falling within any other category DE - Dementia MP - Mental disorder excluding learning disability or dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH - Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** Total number 19: Comprising a maximum of 4 patients in category NH-DE, a maximum of 7 patients in category NH-MP/MP(E) and a maximum of 2 patients in category NH-PH/PH(E). The home is also approved to provide care on a day basis to 1 person.

4.0 Inspection summary

An unannounced inspection took place on 1 June 2017 from 09:30 to 12:15.

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.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to medicine administration, medicine records, storage and the management of controlled drugs.

Patients said they were very satisfied with the care provided.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Pauline Campbell, Nurse 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.

4.2 Action/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- The management of incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

A poster informing visitors to the home that an inspection was being conducted was displayed..

During the inspection we met with two patients, the nurse manager, one registered nurse and one senior care assistant.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

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

Areas for improvements identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met. The

findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 18 May 2017

The most recent inspection of the home was an unannounced care inspection. There were no areas for improvement made as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 1 August 2016

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Two patients care plans were examined. They specified the circumstances under which prescribed medication for administration on a "when required" basis for the management of distressed reactions was to be used.	
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered provider should ensure that pain management care plans are in place and pain assessment tools are in use, where appropriate.	**Met**
	Action taken as confirmed during the inspection: For two patients whose records were examined, pain management care plans were in place and pain assessment tools were in use.	

Area for improvement 3 **Ref**: Standard 29 **Stated:** First time	The registered provider should ensure that the prescribing and administration of thickening agents are recorded.	**Met**
	Action taken as confirmed during the inspection: For one patient whose records were examined, the prescribing and administration of the thickening agent were recorded.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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. Competency assessments were completed annually. Refresher training in medicines management was provided to the registered nurses within the last three years.

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 appropriate arrangements for the storage of prescriptions.

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.

The management of antibiotics and newly prescribed medicines was examined. The advice of the general medical practitioner had been recorded in the patient's notes and the medicines had been obtained without delay. The medicines had been administered appropriately.

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 other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. medicines administered through an enteral feeding tube and warfarin.

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 generally systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The medicine refrigerator and oxygen equipment were checked at regular intervals.

One insulin pen did not have the patient's name recorded on it; another insulin pen had only the patient's initials written on it. Both pens did not have the date of opening recorded. These observations were discussed with the nurse manager who gave an assurance that this matter would be rectified, with the patient's name, date of birth and date of opening being recorded in future. Given this assurance, an area for improvement has not been listed.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessments, the management on medicines on admission and controlled drugs.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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.

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. The reason for and the outcome of administration were recorded. A care plan was maintained.

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. A pain assessment 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 the patient who was prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Administrations were recorded and a care plan and speech and language assessment report was in place.

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. The dates of opening of medicine containers were generally recorded to facilitate audit activity; this is good practice.

Following discussion with the nurse manager and staff and a review of care files, it was evident that, when applicable, other healthcare professionals are contacted in response to the healthcare needs of patients.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

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 spoken with advised that they were very satisfied with the care experienced. 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, we issued questionnaires to patients, patients' representatives and staff. Five patients and one patient's representative completed and returned questionnaires within the specified timeframe. Comments received were positive; the responses were recorded as 'satisfied' or 'very satisfied' with the management of medicines in the home.

Five members of staff also completed a questionnaire. The responses were positive and raised no concerns about the management of medicines in the home.

Areas of good practice

Staff listened to patients and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Written policies and procedures for the management of medicines were in place. Following discussion with staff it was evident that they were familiar with 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.

Staff knew the identity of their adult safeguarding lead. They knew that medicine incidents should be considered under safeguarding procedures and how to report these.

A review of the audit records indicated that satisfactory outcomes had been achieved.

Following discussion with the nurse 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 them.

Areas of good practice

There were examples of good practice in relation to governance arrangements, management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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