Unannounced Medicines Management Inspection Report
20 July 2016

Croaghpatrick

Type of Service: Nursing Home
Address: Miller Hill, 235 Millisle Road, Donaghadee, BT21 0HY
Tel No: 028 9188 8383
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Croaghpatrick took place on 20 July 2016 from 10:00 to 15:30.

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 were trained and competent and there were robust processes for the management of medicines changes and management of high risk medicines. However improvements in the monitoring of medicines which are administered covertly and the storage of medicines are necessary. Two recommendations were made.

Is care effective?

There was evidence that some areas of the management of medicines supported the delivery of effective care for patients. There were systems in place to ensure that patients were administered their medicines as prescribed. Robust arrangements were in place for the management of pain. Improvements in the administration records for medicines and the management of distressed reactions are necessary. One requirement and one recommendation were made.

Is care compassionate?

There was evidence that the management of medicines supported the delivery of compassionate care. Staff interactions with patients were observed to be compassionate, caring and timely. No requirements or recommendations were made.

Is the service well led?

There was evidence that the service was well led with respect to the management of medicines. Written medicine policies and procedures were in place. There were robust systems to manage and share the learning from medicine related incidents. 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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Anne Devoy, 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 estates inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the inspection on 8 June 2016.

2.0 Service details

Registered organisation/registered provider: Four Seasons Healthcare Dr Maureen Claire Royston	**Registered manager:** Mrs Wilhemina (Anne) Devoy
Person in charge of the home at the time of inspection: Mrs Wilhemina (Anne) Devoy	**Date manager registered:** 1 April 2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 67

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 spoke with one patient, two care assistants, three registered nurses 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
- 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 8 June 2016

The most recent inspection of the home was an announced estates inspection. The QIP is in the process of being completed and returned by the home and will be reviewed by the estates inspector on its return. This QIP will be validated by the estates inspector at their next inspection

4.2 Review of requirements and recommendations from the last medicines management inspection dated 19 August 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must closely monitor the management and administration of insulin.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that robust systems were implemented following the last medicines management inspection. Insulin was not prescribed for any patients at the time of the inspection.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 38 **Stated:** First time	The registered person should ensure that the areas identified for improvement on the personal medication records (PMRs) are addressed.	**Met**
	Action taken as confirmed during the inspection: The areas identified for improvement were two signatures for updates, clear dosage directions for liquid medicines, reference to each personal medication record in use and route of administration for eye preparations. A small number of updates had not been verified and signed by two registered nurses; it was agreed that this would be closely monitored. The other three areas had been addressed in a satisfactory manner. As sufficient progress had been made to address this recommendation, it was assessed as being met and not stated for a second time in this report.	

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 team meetings, supervision and annual appraisal. Competency assessments were completed annually. One registered nurse had recently completed her induction and two registered nurses were currently undertaking their induction.

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. The majority of 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. 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. The use of separate administration charts was acknowledged.

Where medicines were being administered covertly this had been authorised by the prescriber and agreed with the patient's relatives. Care plans were in place. However, a number of the audit trails which were carried out on these covertly administered medicines produced unsatisfactory outcomes. A recommendation was made.

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. However, on the ground floor, spacer devices had not been cleaned/replaced in a timely manner, the mouthpiece of one inhaler was not covered and an ointment applicator was observed to be attached to the ointment tube without being cleaned following the previous use. This practice did not comply with infection control standards. A recommendation was made. Medicine storage areas were clean, tidy and well organised on the first floor. 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

The registered provider should ensure that there are robust systems in place to monitor medicines which are administered covertly. A recommendation was made.

The registered provider should ensure that medicines storage meets infection control standards. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.4 Is care effective?

With the exception of the medicines highlighted in Section 4.3, the majority of medicines audited 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, 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 not being recorded on all occasions. A recommendation was made.

The management of pain was reviewed. Detailed care plans were in place. 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. The registered nurses advised that pain assessment tools were used as necessary. The registered manager confirmed that pain assessments were 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. For those patients prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Records of administration were observed to be maintained by both registered nurses and care assistants.

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.

The majority of medicine records were well maintained and facilitated the audit process. However, on the ground floor, some of the medication administration records had not been maintained in a satisfactory manner; there were missed signatures for administration, medicines were signed as administered but remained in the blister pack and the reason for any non-administration had not been recorded. Records of the administration of medicines must be accurately maintained. A requirement was made.

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 and inhaled 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 ensure that medication administration records are accurately maintained. A requirement was made.

The registered provider should ensure that the reason for and outcome of administration of medicines which are prescribed to be administered on a "when required" basis for the management of distressed reactions is recorded. A recommendation was made.

Number of requirements	1	Number of recommendations	1

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.

We spoke with one patient who advised that they were very satisfied with how their medicines were maintained and felt able to request additional pain relief if needed.

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 available in the treatment rooms. 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.

A review of the home's audits indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, action plans were available. However, there was evidence that some of the issues highlighted at this inspection had been identified through the home's audit system and that the identified improvements had not been embedded into practice. The registered manager advised that she plans to become more involved in the audit activity to ensure that the required improvements are implemented and sustained.

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 on an individual basis or though staff 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 this QIP were discussed with Mrs Anne Devoy, 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 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 the 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

Statutory requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 19 August 2016	The registered provider must ensure that medication administration records are accurately maintained.
	Response by registered provider detailing the actions taken: Supervision with Registered Nurses has been completed with regards to the maintenance of medication administration records to ensure their understanding of the importance of accurate record keeping and their responsibilities to ensure complaince with NMC Standards for Medicines Management and FSHC policy and proceedure. Compliance will be monitored through the auditing process.
Recommendations	
Recommendation 1 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 19 August 2016	The registered provider should ensure that there are robust systems in place to monitor medicines which are administered covertly.
	Response by registered provider detailing the actions taken: Medications that are prescribed covertly will have enhanced auditing to ensure medications are administered as prescribed.
Recommendation 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 19 August 2016	The registered provider should ensure that medicines storage meets infection control standards.
	Response by registered provider detailing the actions taken: All inhalers are now stored in covered containers and ointments are stored in the correct manner
Recommendation 3 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 19 August 2016	The registered provider should ensure that the reason for and outcome of administration of medicines which are prescribed to be administered on a “when required” basis for the management of distressed reactions is recorded.
	Response by registered provider detailing the actions taken: Staff supervision has been carried out to ensure staff record the reason for and the outcome of administration of medicines which are prescribed "when required and the management of distressed reactions

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