Unannounced Medicines Management Inspection Report
29 November 2016

Kingsland Care Centre

Type of Service: Nursing Home
Address: 252 Seacliff Road, Bangor, BT20 5HT
Tel no: 02891273867
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Kingsland Care Centre took place on 29 November 2016 from 09:30 to 14:50.

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. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. There were no areas of improvement 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. One area of improvement was identified in relation to the management of medicines prescribed on a "when required" basis for the management of distressed reactions and a recommendation was stated for the second time.

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 of 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. There were no areas of improvement 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	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Susannah Curry, 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 19 October 2016.

2.0 Service details

Registered organisation/registered person: Larchwood Care Homes (NI) Ltd/ Mr Christopher Walsh	**Registered manager:** Ms Susannah Virginia Curry
Person in charge of the home at the time of inspection: Ms Susannah Curry	**Date manager registered:** 29 December 2014
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI.	**Number of registered places:** 43

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.

We met with three patients, the registered manager, the deputy manager, one registered nurse and two care assistants.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

Twenty-five questionnaires were issued to patients, patients' representatives and staff with a request that they were returned within one week from the date of this inspection.

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 19 October 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned on 1 December 2016 and will be reviewed 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 14 October 2015

Last medicines management inspection Recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 28 **Stated:** First time	It is recommended that the dates and times of opening of medicine containers should be routinely recorded in order to facilitate audit activity.	**Met**
	Action taken as confirmed during the inspection: The dates and times of opening were recorded on most medicine containers.	
Recommendation 2 **Ref**: Standard 28 **Stated:** First time	It is recommended that all controlled drugs in Schedule 4 (Part 1) should be denatured and rendered irretrievable before being placed in waste containers.	**Met**
	Action taken as confirmed during the inspection: From discussion with staff and examination of records, it was determined that all controlled drugs in Schedule 4 (Part 1) were denatured and rendered irretrievable before being placed in waste containers.	

Recommendation 3 **Ref**: Standard 28 **Stated:** First time	It is recommended that a robust medicines management audit system should be implemented.	**Met**
	Action taken as confirmed during the inspection: There was recorded evidence that a quarterly medicines audit had been completed. Any issues that had arisen were included in an action plan and they had been discussed at the next staff meeting. Issues arising had been followed up at the next audit to ensure they had been addressed.	
Recommendation 4 **Ref**: Standard 18 **Stated:** First time	It is recommended that if medication is prescribed on a "when required" basis for the management of distressed reactions, the care plan should identify the parameters for its administration and the reason for and outcome of administration should be routinely recorded.	**Not Met**
	Action taken as confirmed during the inspection: Where medication was prescribed on a "when required" basis for the management of distressed reactions, the care plan did not identify the parameters for its administration and the reason for and outcome of administration were not routinely recorded. **This recommendation has been stated for a second time.**	
Recommendation 5 **Ref**: Standard 4 **Stated:** First time	It is recommended that pain management care plans should be in place where appropriate.	**Met**
	Action taken as confirmed during the inspection: Pain management care plans were in place whenever patients could not express pain.	
Recommendation 6 **Ref**: Standard 30 **Stated:** First time	It is recommended that medicines requiring cool storage are stored between 2°C and 8°C.	**Met**
	Action taken as confirmed during the inspection: Medicines requiring cool storage were stored between 2°C and 8°C.	

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. The most recent training was in relation to palliative care.

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 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. The registered manager was advised that it would be good practice to have additional checks performed on other medicines which could be misused e.g. diazepam, lorazepam and tramadol.

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. 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 and 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. However, either the patient did not have a care plan or the care plan did not identify the parameters for the medicine's administration. The reason for and outcome of administration were also generally not recorded. A recommendation was stated for the second time. Two of the patients whose records were examined were administered a regular daily dose of the medication; the registered manager agreed to have this matter referred to the prescriber for review of the dosage directions.

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 assessment tool was used as needed. A care plan was maintained in an instance where a patient could not express pain. Staff also advised that a pain assessment was 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; however, details of the fluid consistency were not routinely recorded. The registered manager gave an assurance that this matter would be rectified without delay. Administrations were recorded and care plans and speech and language assessment reports were 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.

There was recorded evidence that a quarterly medicines audit had been completed. Any issues that had arisen were included in an action plan. The registered manager had notified the nursing staff of any issues and they had been discussed at the next staff meeting. Issues arising had been followed up at the next audit to ensure they had been addressed.

Following discussion with the registered 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

If medication is prescribed on a "when required" basis for the management of distressed reactions, the care plan should identify the parameters for its administration and the reason for and outcome of administration should be routinely recorded. A recommendation was stated for the second time.

Number of requirements	0	**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. Patients spoken to advised that they were very satisfied with the care they received.

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 staff, patients and patients' representatives. One patient completed and returned a questionnaire within the specified timeframe. Comments received were very positive; the responses were recorded as 'very satisfied' with 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. 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.

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.

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.

One of the six recommendations made at the last medicines management inspection had not been addressed. To ensure that this recommendation is addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Susannah Curry, 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 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 to pharmacists@rqia.org.uk 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

Recommendations	
Recommendation 1 **Ref**: Standard 18 **Stated:** Second time **To be completed by:** 28 December 2016	It is recommended that if medication is prescribed on a “when required” basis for the management of distressed reactions, the care plan should identify the parameters for its administration and the reason for and outcome of administration should be routinely recorded.
	Response by registered provider detailing the actions taken: All Care Plans have been reviewed and updated for residents receiving 'when required' medication. Outcome of administration is now routinely recorded on Medicine Administration Record. A follow-up audit will be completed by 31/01/2017 to monitor compliance.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews