Unannounced Medicines Management Inspection Report
14 July 2016

Lough Neagh

Type of Service: Nursing Home
Address: 23 Maghery Road, Portadown, BT62 1SZ
Tel No: 028 3885 2600
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Lough Neagh took place on 14 July 2016 from 09:30 to 13:55.

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. 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. One area of improvement was identified in relation to the recording of controlled drugs. A recommendation was made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. No areas for improvement were identified.

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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Lough Neagh which provides both nursing and residential care.

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 Eileen Quinn, 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 previous QIP there were no further actions required to be taken following the last inspection on 19 May 2016.

2.0 Service details

Registered organisation/registered person: Lough Neagh Nursing Home/ Mr Cathal Quinn Mrs Marie Quinn	**Registered manager:** Ms Eileen Quinn
Person in charge of the home at the time of inspection: Ms Eileen Quinn	**Date manager registered:** 21 April 2015
Categories of care: NH-DE, NH-I, RC-PH, NH-PH, RC-I, NH-LD	**Number of registered places:** 26

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 the front door 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 three patients, the registered manager and one nurse.

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 May 2016

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector. 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 11 November 2014

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should review the policies and procedures in place to ensure standard operating procedures for controlled drugs and the disposal of medicines are included.	**Met**
	Action taken as confirmed during the inspection: The policies and procedures had been reviewed to ensure standard operating procedures for controlled drugs and the disposal of medicines were included.	
Recommendation 2 **Ref**: Standard 38 **Stated:** First time	The registered manager should ensure that the practice of administering bisphosphonates prior to breakfast is reflected in the medicine administration records.	**Met**
	Action taken as confirmed during the inspection: The practice of administering bisphosphonates prior to breakfast was reflected in the medicine administration records.	

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 general medicines management was provided within the last two 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. Robust arrangements were in place for ensuring supplies of acute prescriptions such as antibiotics were obtained and administered in a timely fashion.

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. However, one recent receipt of a controlled drug and one recent disposal of a controlled drug had not been entered in this record book; a recommendation was made. Checks were performed on controlled drugs which require safe custody, at the end of each shift. The need for the controlled drug stock to be directly checked with the stock balance recorded in the controlled drug record book was discussed and the registered manager gave an assurance that this practice would be implemented with immediate effect. Additional checks were also performed on other controlled drugs, which is good practice.

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 manufacturers' 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. The medicine refrigerator and oxygen equipment were checked at regular intervals.

Areas for improvement

The controlled drug record book should be fully and accurately maintained.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

The majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. A couple of discrepancies were noted. The registered manager gave an assurance that she would increase the audits on these medicines to ensure they are being administered in accordance with the prescribed dosage 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 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 parameters for administration were recorded on the personal medication record. A care plan was maintained. The reason for and outcome of administration had mostly been recorded. 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 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 a pain assessment was completed as part of the admission process. A pain assessment tool was completed and updated as necessary. A care plan was maintained and it was evaluated on at least a monthly basis.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record; however, the fluid consistency was not always recorded. The registered manager gave an assurance that this matter would be rectified without delay. Each administration was 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 maintained in a satisfactory manner and facilitated the audit process. For nutritional feeds, administered via the enteral route, the rate of flow and/or frequency of dosing were not specified on the personal medication record; the registered manager gave an assurance that this would be rectified.

Practices for the management of medicines were audited on an ongoing basis. The dates and times of opening of the medicine containers were recorded in order to facilitate audit; this was acknowledged as good practice.

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

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

The administration of medicines to several patients was observed during the inspection. Medicines were administered to patients in the dining room or in their room. The nurses administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to swallow each medicine. Extra time and attention was given to patients who had difficulty swallowing some of the medicines. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

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 able to ask for and had received pain relief when necessary. Patients stated that they were “well-cared for” and “very happy”.

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. These had been reviewed and updated since the previous medicines management inspection. Following discussion with staff, it was evident that they were knowledgeable of 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.

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

Following discussion with the registered manager and nurse, 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.

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 issue identified during this inspection is detailed in the QIP. Details of this QIP were discussed with Ms Eileen Quinn, 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	
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 13 August 2016	The registered provider should ensure that the controlled drug record book is fully and accurately maintained.
	Response by registered provider detailing the actions taken: Refresher training carried out with staff. Monitoring included in weekly audit.

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

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