

# Unannounced Medicines Management Inspection Report 25 May 2017



## Lough Neagh

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

[www.rqia.org.uk](http://www.rqia.org.uk)

## 1.0 Summary

An unannounced inspection of Lough Neagh took place on 25 May 2017 from 09:40 to 13:10.

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 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 for improvement identified.

### **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. There were no areas for improvement identified.

### **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 for 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 for 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.

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

## 1.1 Inspection outcome

	Requirements	Recommendations
<b>Total number of requirements and recommendations made at this inspection</b>	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Ms Eileen Quinn, Registered 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.

## 1.2 Actions/enforcement taken following the most recent finance inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 14 March 2017.

## 2.0 Service details

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

## 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 met with three patients, the registered manager, the nursing sister, 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.

Fifteen 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
- care plans
- training records
- medicines storage temperatures

#### 4.0 The inspection

#### 4.1 Review of requirements and recommendations from the most recent inspection dated 14 March 2017

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was returned and approved by the finance inspector. This QIP will be validated by the finance inspector at their next inspection.

#### 4.2 Review of requirements and recommendations from the last medicines management inspection dated 14 July 2016

Last medicines management inspection recommendations		Validation of compliance
<b>Recommendation 1</b> <b>Ref:</b> Standard 29 <b>Stated:</b> First time	The registered provider should ensure that the controlled drug record book is fully and accurately maintained.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> The controlled drug record book had been appropriately maintained.	

#### 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. Refresher training in medicines management was provided in the last year. The most recent training was in relation to diabetes management.

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 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.

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 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**

No areas for improvement were identified during the inspection.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	0
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**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 or three monthly medicines were due.

The management of antibiotics and new 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.

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. Staff advised that most of the patients could verbalise any pain, and a pain 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 those patients prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. 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 well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the routine recording of the dates of opening of medicine containers to facilitate audit activity.

Practices for the management of medicines were audited by management. This activity involved auditing several randomly selected medicines (usually either Adcal or analgesics) each month. There was no recorded evidence that the audit activity extended beyond this. The need for the registered manager to review the current audit process, in order to ensure there are robust arrangements in place to audit all aspects of the management of medicines, was discussed. The registered manager gave an assurance that this would be done. The value of using a checklist audit tool and expanding the range of medicines audited was discussed.

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

**Areas for improvement**

No areas for improvement were identified during the inspection.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	0
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**4.5 Is care compassionate?**

The administration of medicines to patients had been completed before the commencement of this inspection and was therefore not observed.

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. Two patients completed and returned questionnaires within the specified timeframe. Comments received were very positive; the responses were recorded as ‘satisfied’ or ‘very satisfied’ with the management of medicines in the home.

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

**Areas for improvement**

No areas for improvement were identified during the inspection.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	0
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**4.6 Is the service well led?**

Written policies and procedures for the management of medicines were in place. Management advised that these were reviewed on a regular basis. 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. The medicine related incident reported since the last medicines management inspection was discussed.

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

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

Following discussion with the nursing sister, 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.

**Areas for improvement**

No areas for improvement were identified during the inspection.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	0
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**5.0 Quality improvement plan**

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.



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