Whitehead Nursing Home
RQIA ID:1438
15 -18 Marine Parade
Whitehead
BT38 9QP

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Unannounced Medicines Management Inspection of Whitehead Nursing Home

30 September 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced medicines management inspection took place on 30 September 2015 from 10:50 to 15:00.

Overall on the day of the inspection the management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no significant areas of concern, though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

This inspection was underpinned by 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 Whitehead Nursing Home which provides both nursing and residential care.

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last medicines management inspection on 16 May 2012.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	0

The details of the QIP within this report were discussed with the registered manager, Mrs Cara Parker, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Whitehead Nursing Home Ltd Mr Robert Desmond Wilson	**Registered Manager:** Mrs Cara Parker
Person in Charge of the Home at the Time of Inspection: Mrs Cara Parker	**Date Manager Registered:** 16 January 2015
Categories of Care: NH-LD(E), RC-DE, RC-I, RC-PH(E), RC-MP(E), NH-I, NH-PH A maximum of 12 residential places including 4 identified residents in category RC-DE. 1 identified patient in category NH-LD(E)	**Number of Registered Places:** 41
Number of Patients Accommodated on Day of Inspection: 39 (Nursing x 29 and Residential x 10)	**Weekly Tariff at Time of Inspection:** £470 - £593

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and to determine if the following standards and themes have been met:

Standard 28: Management of Medicines
Standard 29: Medicines Records
Standard 31: Controlled Drugs

Theme 1: Medicines prescribed on a “when required” basis for the management of distressed reactions are administered and managed appropriately

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to the inspection, the inspector reviewed the management of medicine related incidents reported to RQIA since the last medicines management inspection.

During the inspection the inspector met with the registered manager and staff on duty.

The following records were examined during the inspection:

Medicines requested and received	Medicine audits
Personal medication records	Policies and procedures
Medicines administration records	Care plans
Medicines disposed of or transferred	Training records
Controlled drug record book	Medicine storage temperatures.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 15 June 2015. The completed QIP was assessed and approved by the care inspector on 16 July 2015.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Inspection

Last Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref**: Regulation 13(4) **Stated three times**	All incoming medicines must be recorded appropriately.	**Met**
	Action taken as confirmed during the inspection: A detailed record of the receipt of each of the medicines audited at the inspection had been maintained.	
Requirement 2 **Ref**: Regulation 13(4) **Stated first time**	Where designated care assistants have been delegated medicines related tasks, the registered manager must ensure that records of training and competency are maintained.	**Met**
	Action taken as confirmed during the inspection: Care assistants were provided with annual training in the administration of external preparations and the management of dysphagia. A sample of training records was observed at the inspection. Competency was assessed through supervision sessions, observation of rounds and at annual appraisal.	

Last Inspection Statutory Requirements		Validation of Compliance
Requirement 3 **Ref**: Regulation 13(4) **Stated first time**	The registered manager must report the ongoing-non-administration of two patients' eye drops, to the prescriber.	**Met**
	Action taken as confirmed during the inspection: The completed QIP stated that this had been reported to the prescriber within the specified timescale. There was no evidence of any ongoing-non-administration of eye preparations at the inspection.	
Requirement 4 **Ref:** Regulation 13(4) **Stated first time**	The registered manager must put the necessary safeguards in place to ensure the accuracy of the details of the prescribed medicines on personal medication records.	**Partially Met**
	Action taken as confirmed during the inspection: The writing of new personal medication records had involved two registered nurses and both had signed the record at the time of writing. Where new medicines were prescribed or there was a change to a medicine dose, only one registered nurse had been involved in recording the details on this record. It was acknowledged that two registered nurses verified handwritten entries on the medication administration records. This was further discussed with the staff at the inspection. It was concluded there had been some misunderstanding and the registered manager provided assurance that this would be the practice from the day of the inspection onwards. This requirement has been partially met, however, due to the assurance provided by the registered manager, it has not been restated.	

Last Inspection Statutory Requirements		Validation of Compliance
Requirement 5 **Ref**: Regulation 13(4) **Stated first time**	The registered manager must ensure there are robust procedures in place for the cold storage of medicines.	**Met**
	Action taken as confirmed during the inspection: Robust arrangements were in place for the management of medicines which require cold storage. Medicines were stored at the correct temperature and there was signage in place to remind staff to reset the thermometer.	

Last Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 37 **Stated first time**	The registered manager should develop Standard Operating Procedures for controlled drugs.	**Met**
	Action taken as confirmed during the inspection: A copy of the Standard Operating Procedures regarding the management of controlled drugs were in place.	
Recommendation 2 **Ref**: Standard 38 **Stated first time**	The registered manager should make the necessary arrangements to ensure that nurses are recording the appropriate code for the non-administration of medicines.	**Met**
	Action taken as confirmed during the inspection: This practice was observed. A reason for any non-administration of a medicine had been recorded and the correct code had been stated.	

Last Inspection Recommendations		Validation of Compliance
Recommendation 3 **Ref**: Standard 37 **Stated first time**	The registered manager should ensure that the required consistency level of thickened fluid is recorded on the personal medication record and administration records.	**Partially Met**
	Action taken as confirmed during the inspection: The required consistency level was not recorded on the personal medication record but was recorded on the administration records. The registered manager advised that this would be addressed after the inspection. This recommendation has been partially met; however, due to the assurance provided by the registered manager, it has not been restated.	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

Several medicines and medicine records were audited at the inspection. The audits produced satisfactory outcomes indicating medicines were administered as prescribed.

There was evidence that written confirmation of medicine regimes had been obtained for new patients. The medicines were recorded on the personal medication records and handwritten medication administration records and verified by a second registered nurse.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available. However, it was noted that in a previous medicine cycle, there had been insufficient supplies of three medicines, which had resulted in the non-administration of medicines; for one medicine this equated to 14 missed doses. This had not been brought to the registered manager's attention and had not been reported to RQIA. All of the prescribed medicines were available for administration on the day of the inspection.

Medicines were prepared immediately prior to their administration from the container in which they were dispensed. All of the medicines examined at the inspection were labelled appropriately.

There were suitable systems in place to manage any medicine changes including dose changes for anticoagulant medicines.

Overall, medicine records were legible and accurately maintained so as to ensure that there was a clear audit trail. Records of the prescribing, ordering, receipt, administration, non-administration, disposal and transfer of medicines were maintained. All of the personal

medication records examined had been signed by two registered nurses to ensure the accuracy of the record. The majority of these had been recently rewritten. However, some personal medication records entries and administration records regarding external preparations were incomplete or were not up to date. Areas of good practice included the use of separate administration charts for transdermal patches and injectable medicines.

The receipt, storage, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Stock reconciliation checks were performed on controlled drugs which require safe custody, at each transfer of responsibility.

The majority of discontinued or expired medicines were discarded by two registered nurses into pharmaceutical clinical waste bins which were uplifted by a waste disposal contractor. The waste transfer note was attached to the disposal record. Staff advised that occasionally, some medicines would be returned to the community pharmacy for disposal. Controlled drugs were denatured by two registered nurses prior to disposal.

The management of thickening agents was reviewed. It was noted that the consistency level recorded on the administration records did not correlate with the most recent speech and language therapist's recommendation.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines including Standard Operating Procedures for controlled drugs in Whitehead Nursing Home were in place. There was evidence that these had been reviewed in the last three months.

Medicines were managed by staff who had been trained and deemed competent to do so, following a period of induction. The registered manager confirmed that the impact of training was monitored through team meetings, supervision and annual appraisal. A sample of records was provided. General medicines management training had been completed on an annual basis. A list of the names, signatures and initials of registered nurses was maintained. Refresher training for care staff in the administration of external preparations and dysphagia had been completed. The next training was scheduled for 13 October 2015.

Practices for the management of medicines have been audited on a regular basis. Registered nurses had maintained running stock balances for warfarin and most other medicines which were not included in the 28 day blister packs. This is good practice. The community pharmacist has also completed audits on a periodic basis. The audit process has been was facilitated by the good practice of recording the date and time of opening on medicine containers and also recording the quantity of any medicine carried forward into the next medicine cycle.

There were procedures in place to report and learn from any medicine related incidents that had occurred in the home. The medicine incidents reported to RQIA since the last medicines management inspection were managed appropriately.

Is Care Compassionate? (Quality of Care)

The records pertaining to a small number of patients who were prescribed medicines on a "when required basis" for the management of distressed reactions were examined at the inspection. A care plan was maintained and evaluated monthly. The parameters for administration of anxiolytic medicines were recorded on the personal medication records. The audits indicated that these medicines were administered infrequently. A record of the administration was also maintained in the patient's daily notes which stated the reason for and outcome of the administration. From discussion with the staff, it was concluded that staff were familiar with circumstances when to administer anxiolytic medicines. Staff had the knowledge 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.

Of the sample of records examined, medicines which were prescribed to manage pain were recorded on the patient's personal medication record. These medicines had been administered as prescribed. This included regularly prescribed controlled drug patches and analgesics which were prescribed for administration on a "when required" basis. A pain score chart for analgesics was completed for each administration and detailed the level and area of pain and also included a running stock balance. This is good practice. From discussion with the registered nurses, it was evident that staff were aware of the signs, symptoms and triggers of pain in patients and that ongoing monitoring was necessary to ensure the pain was well controlled and the patient was comfortable. Care plans in relation to pain management were in place and were evaluated each month. A pain tool was in use.

Areas for Improvement

The stock control of medicines must be reviewed and systems implemented to ensure that out of stock situations are prevented. A requirement was made. The registered manager gave an assurance that any further incidents regarding out of stock medicines would be reported to RQIA.

The management of external preparations must be reviewed to ensure that personal medication records and administration records are fully and accurately completed. A requirement was made.

The registered manager confirmed that any changes to personal medication records would be signed and verified by two registered nurses and that this area of medicines management would be included in the audit process.

Staff were reminded that any non-administered medicines, for example, due to a hospital admission, should also be placed into the clinical waste bin and records maintained.

The registered manager confirmed that the issue identified in relation to the prescribed consistency level of thickened fluid would be followed up immediately after the inspection.

Number of Requirements	2	**Number of Recommendations**	0

5.4 Additional Areas Examined

Medicines storage areas were tidy and organized. Medicines were stored safely and securely in accordance with the manufacturers' instructions.

Dates of opening were recorded on medicines with a limited shelf life once opened.

6. Quality Improvement Plan

The issue identified during this inspection is detailed in the QIP. Details of this QIP were discussed with the registered manager, Mrs Cara Parker, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The DHPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes (2015). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Person/Registered Manager

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to pharmacists@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated: First time** **To be Completed by:** **30 October 2015**	The registered person must review the stock control of medicines to ensure that out of stock situations are prevented.
	Response by Registered Person(s) Detailing the Actions Taken: All staff are aware that drugs must be ordered brom the GP 72 hrs prior to last dosage to prevent stock shortages.
Requirement 2 **Ref**: Regulation 13(4) **Stated: First time** **To be Completed by:** **30 October 2015**	The registered person must ensure that robust arrangements are in place for the management of external preparations.
	Response by Registered Person(s) Detailing the Actions Taken: Training has been arranged for all care staff re the completion of external preparations. Documentation audits to be carried out and regular checks are to be carried out by senior staff.

Registered Manager Completing QIP	Cara Parker	**Date Completed**	23.10.15
Registered Person Approving QIP	Desmond Wilson	**Date Approved**	26.10.15
RQIA Inspector Assessing Response	**Judith Taylor**	**Date Approved**	**26.10.15**

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