

# Unannounced Medicines Management Inspection Report 29 November 2016



## Ashbrook Care Home

Type of Service: Nursing Home  
Address: 50 Moor Road, Coalisland, Dungannon BT71 4QB  
Tel No: 028 8774 1010  
Inspector: Cathy Wilkinson

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

Assurance, Challenge and Improvement in Health and Social Care

## 1.0 Summary

An unannounced inspection of Ashbrook Care Home took place on 29 November 2016 from 10.15 to 13.15.

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 supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. There were no areas of 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 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. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

For the purposes of this report, the term 'patients' will be used to describe those living in Ashbrook Care Home 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 Miss Gillian Larmour, 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 care inspection

There were no further actions required to be taken following the most recent inspection.

## 2.0 Service details

<b>Registered organisation/registered person:</b> Ashbrook Home Ltd Mr Marcus James Mulgrew	<b>Registered manager:</b> Miss Gillian Larmour
<b>Person in charge of the home at the time of inspection:</b> Miss Gillian Larmour	<b>Date manager registered:</b> 26 July 2016
<b>Categories of care:</b> NH-PH, RC-I, NH-DE, NH-I, NH-MP(E)	<b>Number of registered places:</b> 68

## 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, four registered nurses and the registered manager.

A total of 20 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA within one week. Fourteen questionnaires were returned on the day of the inspection.

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.

A sample of the following records was examined:

- 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 2 June 2016

The most recent inspection of the home was an unannounced care inspection. There were no requirements or recommendations made following this inspection.

### 4.2 Review of requirements and recommendations from the last medicines management inspection 30 July 2013

Last medicines management inspection statutory requirements		Validation of compliance
<b>Requirement 1</b> <b>Ref:</b> Regulation 13(4) <b>Stated:</b> First time	The registered manager must review the arrangements for recording the use of topical medicines in order to ensure that care staff are making a specific record of each treatment applied.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> The application of topical medicines by care assistants is recorded appropriately. A sample of records was provided for inspection.	

Last medicines management inspection recommendations		Validation of compliance
<b>Recommendation 1</b> <b>Ref:</b> Standard 37 <b>Stated:</b> First time	The standard operating procedures detailing the arrangements for the management of controlled drugs should be expanded to cover storage and security, monitoring and audit, as well as errors and incidents.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> Standard operating procedures for the management of all aspects of controlled drugs were in place. They had been reviewed in April 2016.	
<b>Recommendation 2</b> <b>Ref:</b> Standard 37 <b>Stated:</b> First time	A policy and procedure should be written detailing the arrangements for the management of warfarin.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> A policy and procedure was in place and had been reviewed in December 2015.	
<b>Recommendation 3</b> <b>Ref:</b> Standard 37 <b>Stated:</b> First time	A policy and procedure should be written detailing the arrangements for the management of thickening agents.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> A policy and procedure was in place and had been reviewed in December 2015.	

#### 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. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Training in medicines management, the management of gastrostomy tubes, syringe drivers and anaphylaxis had been provided in the last year.

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 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.

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 and insulin. The use of separate administration charts was acknowledged.

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. Medicine refrigerators 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, 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, 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. There was evidence that the patient’s pain was assessed prior to the administration of these medicines. This good practice was commended. 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. Pain assessment tools were completed regularly and in some cases several times per day. A care plan was maintained. Staff also advised that a pain assessment is completed as part of the admission process.

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.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicines that had

previously shown that further monitoring was required. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that other healthcare professionals are contacted when required to meet the 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?

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients were treated courteously, with dignity and respect. Good relationships were evident. All staff that were assisting patients were observed to be fully engaged in conversation with them. The atmosphere in the home was warm and welcoming to visitors who were greeted by staff.

The administration of medicines to several patients was observed during the inspection. The nurse administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to swallow each medicine. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

Questionnaires were completed by seven residents and one patient's representative. All of the responses in the questionnaires indicated that patients were either "satisfied" or "very satisfied" with how medicines are managed in the home.

Six members of staff completed the questionnaire. All of the responses were positive and raised no concerns with how medicines were managed within the home.

We spoke to two patients who expressed no concerns about their care in the home. 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.

<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 which were reviewed regularly. 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 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 and registered nurses, 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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