Unannounced Medicines Management Inspection Report
6 August 2018

Owen Mor Care Centre

Type of Service: Nursing Home
Address: 167 Culmore Road, Londonderry, BT48 8JH
Tel No: 028 7135 3631
Inspector: Judith Taylor

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 81 beds that provides care for patients living with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: East Eden Ltd **Responsible Individual:** Dr Brendan McDonald	**Registered Manager:** Mrs Jane Laird
Person in charge at the time of inspection: Mrs Jane Laird	**Date manager registered:** 5 June 2015
Categories of care: Nursing Homes (NH) DE - Dementia LD - Learning disability LD(E) - Learning disability – over 65 years MP - Mental disorder excluding learning disability or dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH - Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 81 comprising: • a maximum of 58 patients in category NH-DE: ○ 17 accommodated in the Faughan Unit ○ 20 accommodated in the Foyle/Roe Unit ○ 10 accommodated in the Derg Unit ○ 11 accommodated in the Finn Unit • a maximum of 10 patients in category NH-PH/PH(E) accommodated in the Mourne Unit • a maximum of 7 patients in category NH-LD/LD(E) accommodated in the Strule Unit • a maximum of 6 patients in category NH-MP/MP(E) accommodated in the Erne Unit

4.0 Inspection summary

An unannounced inspection took place on 6 August 2018 from 10.20 to 17.00.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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.

The inspection assessed progress with any areas for improvement identified during and since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to training, competency assessment, the administration of most medicines, care planning and the storage of medicines.

Areas for improvement were identified in relation to the stock control of medicines, the management of controlled drugs, the standard of record keeping and the management of incidents. One of the areas for improvement against the standards was stated for the second time.

Patients were observed to be relaxed and comfortable in their environment and in their interactions with staff. We noted the warm and welcoming atmosphere in the home.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	2	*3

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Jane Laird, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the two day inspection which commenced on 10 April 2018. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

- 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

A poster was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

During the inspection we met with four registered nurses, one care assistant, the registered manager and the registered provider.

We provided the registered manager with 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. We asked the registered manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

A sample of the following records was 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

We left 'Have we missed you' cards in the home to inform patients and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 10 & 11 April 2018

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

6.2 Review of areas for improvement from the last medicines management inspection dated 27 April 2017

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time	The registered provider should ensure that all medicines are labelled appropriately.	**Met**
	Action taken as confirmed during the inspection: The medicines selected for audit at the inspection were appropriately labelled.	
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time	The registered provider should ensure that records of the receipt and administration of medicines are fully and accurately maintained.	**Partially met**
	Action taken as confirmed during the inspection: There was evidence of improvement in relation to the receipt of medicines; however, a record of one patient's incoming medicines could not be located. In relation to medicine administration records, we observed that some	

	of these had not been fully and accurately maintained. See Section 6.5. This area for improvement is stated for a second time.	
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time	The registered provider should further develop the audit process for medicines management.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the audit process had been reviewed and new systems developed.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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 the management of medicines, enteral feeding, palliative care and dementia was provided in the last year. The registered manager advised that there was ongoing support regarding medicines management from the community pharmacist and also a pharmacist from the Western Health and Social Care Trust. In relation to safeguarding, training was completed annually.

There were largely satisfactory procedures in place to ensure the safe management of medicines during a patient's admission to the home and for the management of medicine changes. Written confirmation of the patient's medicine regime was obtained and personal medication records were signed by two registered nurses. This safe practice was acknowledged. Antibiotics and new medicines had been received into the home without delay. However, for one new patient, it was noted that two medicines were recorded on the personal medication record, but were not held in stock. We established that one medicine had been discontinued prior to admission and the other medicine had not been received. The registered manager gave assurances that she would follow this up immediately after the inspection.

The ordering and stock control of medicines was reviewed. Although we were advised of the systems in place to ensure that medicines were available for administration, we noted that some patients did not have a continuous supply of their medicines and as a result were not administered some of their medicines. Staff advised of the continued efforts to obtain these medicines; however, these issues had not been reported to the registered manager or recognised by staff as medicine related incidents. The potential impact to the patients and the need to ensure that medicines were available for administration was discussed. An area for improvement was identified. See also Section 6.7.

The management of controlled drugs was reviewed. Controlled drugs which require safe custody were stored in the controlled drug cabinet; arrangements were in place to check stock balances of controlled drugs which require safe custody and other controlled drugs at each shift check. We noted some discrepancies in the controlled drug book and that Schedule 4 controlled drugs were not always denatured prior to disposal. An area for improvement was identified. The need for staff to refer to the organisation's Standard Operating Procedures for controlled drugs was also discussed.

Robust arrangements were observed for the management of high risk medicines e.g. insulin. Separate administration charts with running stock balances were maintained. This good practice was acknowledged. A care plan was in place. It was agreed that the dosage of insulin would be added to the patient's care plan.

There were largely satisfactory arrangements in place for the safe disposal of medicines. An area for improvement relating to controlled drugs was made above.

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 of good practice

There were examples of good practice in relation to staff training, competency assessment and the storage of medicines.

Areas for improvement

The necessary arrangements should be made to ensure that all medicines are available for administration to patients as prescribed.

The management of controlled drugs should be reviewed to ensure that robust arrangements are in place.

	Regulations	Standards
Total number of areas for improvement	2	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. However, some discrepancies were observed and discussed with staff and the registered manager for close monitoring. We could not complete the audit trails on one patient's medicines as a record of the receipt of medicines was not available.

There was evidence that time critical medicines had been administered at the correct time. Whilst there were arrangements in place to remind staff when doses of alternate day and weekly medicines were due, we observed that one weekly patch had been omitted in error. See below.

The management of pain was reviewed. This was referenced in a care plan and a pain assessment was completed for each patient at admission, monthly or more frequently as needed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. With the exception of one weekly controlled drug patch, the sample of records examined indicated that pain relieving medicines had been administered as prescribed. In relation to this patch, staff had omitted to change the patch as prescribed. The management of this patient's pain was discussed and we were advised that this patient could express pain. The registered manager assured us that this would be investigated with immediate effect. An area for improvement in relation to controlled drugs was made in Section 6.4.

We reviewed the arrangements in place to manage distressed reactions for three patients. The medicine and dosage was clearly recorded on the personal medication records and a care plan was in place for two of the patients. The other patient's care plan was developed during the inspection. 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 in the care notes.

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. We observed that where a patient had difficulty swallowing medicines, liquid formulations were prescribed. In the instances where a patient had continually refused medicines there was evidence that this had been discussed at a multidisciplinary team meeting and a care plan was put in place to administer medicines in disguised form.

However, for one patient, we noted discrepancies in the audit outcomes regarding inhaled medicines. The records indicated that the inhalers were being given but the registered nurses advised that they were being refused and this had not been recorded on the administration records. There was no evidence to indicate that this refusal was reported to the prescriber and referenced in a care plan. Staff advised that the prescriber was aware in relation to one of the inhaled medicines. An area for improvement was identified.

Most of the medicines records were well maintained and facilitated the audit process. In relation to the records of administration, there was evidence of code-copying, where staff had copied the codes from the previous day; and if the medicine was not administered, the actual reason for this was not clearly recorded. The area for improvement identified at the last medicines management inspection was stated for a second time (see Section 6.2).

Practices for the management of medicines were audited by staff and management. We were advised of the process which ensures that each patient's medicines were audited at least monthly. The date of opening was routinely recorded on medicines supplied in original boxes and also the 28 day blister packs to facilitate the audit process.

Areas of good practice

Some examples of good practice were observed in relation to the completion of personal medication records, the management of distressed reactions and care planning.

Areas for improvement

An area for improvement under standards, regarding the completion of receipt and administration records has been stated for a second time.

The ongoing refusal of one patient's medicines should be referred to the prescriber and the outcomes recorded in the patient's records.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Some of the patients were engaging in activities and staff were noted to be taking their time with the patients.

We noted the warm and welcoming atmosphere in the home. Throughout the inspection, it was found that there were good relationships between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity. It was clear from discussion and observation of staff, that they were familiar with the patients' likes and dislikes.

It was not possible to ascertain the views and opinions of patients at this inspection. However, they were observed to be relaxed and comfortable in their surroundings and in their interactions with staff and other patients.

Of the questionnaires which were distributed, none were returned from patients/patients representatives within the specified time frame (two weeks). Any comments in questionnaires received after this time frame will be shared with the registered manager as necessary.

Areas of good practice

Staff listened to patients and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The inspector discussed arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. We were advised that there were arrangements in place to implement the collection of equality data within Owen Mor Care Centre.

Written policies and procedures for the management of medicines were in place. A copy was kept in each treatment room for staff reference.

The management of medicine related incidents was examined. Whilst staff confirmed that they knew how to identify and report incidents and advised of the procedures in place, it was highlighted that when medicines were out of stock this had not been identified or reported to the registered manager (see also Section 6.4); an area for improvement was made. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were reviewed. We were advised of the audits which take place and how areas for improvement were identified and followed up. This was usually through sharing the information via the staff text system, memos and meetings. A sample of the audit outcomes was provided. The registered manager advised that she completed a walk around the home each morning and in relation to medicines management, she visited each of the four treatment rooms to review medical equipment checks and temperatures of storage areas.

One of the areas for improvement made at the last medicines management inspection had been not been addressed effectively. To ensure that this is fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process. As other areas for improvement were identified at this inspection, the registered manager advised that a staff meeting would be held to address the findings.

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.

The staff we met with spoke positively about their work and the working relationships in the home and with other healthcare professionals. All of the staff stated they felt well supported in their work and advised they had no concerns.

The registered manager and staff advised that there were effective communication systems in the home to ensure that staff were kept up to date. Shift handovers were verbal with registered nurses and care staff in attendance.

No online questionnaires were completed by staff within the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to governance arrangements and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

The management of incidents should be reviewed.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Jane Laird, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 6 September 2018	The registered person shall review the stock control of medicines to ensure that all patients receive their medicines as prescribed. Ref: 6.4
	Response by registered person detailing the actions taken: Staff Nurses educated regarding the importance of ensuring that all patient's receive their prescribed medication and the actions to take if medication is not available. Clinical Leads within each department to ensure that monthly medication orders are received and in stock for each patient.
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 6 September 2018	The registered person shall ensure that robust arrangements are in place for the management of controlled drugs. Ref: 6.4
	Response by registered person detailing the actions taken: Clinical Leads/Staff Nurses educated regarding the controlled drug register to reflect the medication within the controlled drug cabinet. Controlled drugs for patient's who have been discharged must be signed out of the register by two registered nurses with a clear record of whether they have been returned to the family or denatured as per home policy. Clinical Lead to carry out a spot check monthly on the controlled drug register within their unit and to liaise with the manager if any discrepancies identified.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 29 **Stated:** Second time **To be completed by:** 6 September 2018	The registered provider should ensure that records of the receipt and administration of medicines are fully and accurately maintained. Ref: 6.2 & 6.5
	Response by registered person detailing the actions taken: Staff Nurses/Clinical Leads updated regarding the homes policy on recording of drugs on admission which must be signed in by two registered nurses. The drug kardex must reflect the drugs on admission and have either a hospital discharge letter/GP script detailing the medication regime for the patient. The drug Kardex must be signed by two registered nurses. Staff Nurses have been provided with written information about the errors that were identified during the inspection around the administration of medication, code - copying and the omission of drugs without providing a clear explanation for same. Instructions for

	improvement were provided and a new form was created for nurses to provide a reason for any omission of drugs going forward. All Staff Nurses have signed to verify that they have read and understand the errors that they have made and their responsibility to ensure that medication is administered accurately at all times in line with the NMC code. Drug audits are carried out monthly on each patient and at the end of each box/bottle. Any discrepancies are reported to the manager immediately and relevant action taken as required. Clinical Leads have been educated regarding the stock and availability of medication to ensure that the patient always has their prescribed drugs and the importance of escalating out of stock medication to the manager immediately.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 6 September 2018	The registered person shall ensure that the ongoing refusal of one patient's medicine has been reported to the prescriber and details are recorded in the patient's care plan. Ref: 6.5
	Response by registered person detailing the actions taken: GP contacted regarding the ongoing refusal of a patient's prescribed medication and same was discontinued. NOK and care manager made aware. Care plans and risk assessments updated.
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 6 September 2018	The registered person shall review the management of incidents. Ref: 6.7
	Response by registered person detailing the actions taken: Staff Nurses/Clinical Leads educated regarding the homes policy on reporting incidents immediately to the home manager.Informed that all incidents must be documented and reported to the NOK, care manager, RQIA and GP where necessary.

Please ensure this document is completed in full and returned via the Web Portal

The Regulation and Quality Improvement Authority

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

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews