Unannounced Post-Registration Medicines Management Inspection Report
5 September 2018

Dunmurry Manor Residential Care Home

Type of Service: Residential Care Home
Address: 2A Hazel Avenue, Dunmurry, Belfast, BT17 9QU
Tel No: 028 9061 0435
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 provider 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 residential care home with 36 beds that provides care for residents living with dementia.

This home is situated in the same building as Dunmurry Manor Nursing Home.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Mr Gavin O'Hare-Connolly	**Registered Manager:** Mrs Julie McKearney
Person in charge at the time of inspection: Ms Lisa Gibson (Unit Manager)	**Date manager registered:** 6 July 2018
Categories of care: Residential Care (RC) DE – Dementia	**Number of registered places:** 36

4.0 Inspection summary

An unannounced inspection took place on 5 September 2018 from 09.50 to 15.10.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

The inspection assessed progress with any areas for improvement identified since the pre-registration care 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 the governance arrangements, training, the completion of most medicine records, the administration of most medicines, the management of controlled drugs and the storage of medicines.

Areas for improvement were identified in relation to monitoring of medicines administration and medicine records and completion of a care plan.

Residents said they were happy in the home and spoke positively about the management of their medicines and the care provided by staff. They were noted to be content in their interactions with staff and other residents.

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

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	3

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Lisa Gibson, Unit 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 pre-registration care inspection

No further actions were required to be taken following the most recent inspection on 7 June 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 incidents: it was ascertained that no incidents involving medicines had been reported to RQIA since the home registered.

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

During the inspection the inspector met with three residents, two residents' relatives, three members of care staff and the unit manager.

We provided 10 questionnaires to distribute to residents and their representatives, for completion and return to RQIA and we asked the unit 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 residents 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.

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 7 June 2018

The most recent inspection of the home was an announced pre registration care inspection. There were no areas for improvement made as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection

This was the first medicines management inspection to the home since it was separately registered as a residential care home.

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. Staff competency assessments were completed following induction, and then at least annually or more frequently as required. The impact of training was monitored through team meetings, supervision and annual appraisal. A sample of training and competency records was provided. Refresher training in the management of medicines, dementia and dysphagia was completed earlier this year.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and for the management of medicine changes. Written confirmation of medicine regimes and any medicine changes were obtained. Personal medication records and medication administration records were updated by two trained staff. This is safe practice and was acknowledged.

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, report and follow up any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed.

The management of controlled drugs was reviewed. 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.

Community nurses were responsible for the administration of insulin and blood monitoring. We were advised that all relevant staff were familiar with the signs and symptoms of changes in blood sugar levels.

Discontinued or expired medicines including controlled drugs were returned to the community pharmacy for disposal.

Medicines were being stored safely and securely and in accordance with the manufacturer's instructions. There were satisfactory systems in place to manage medicines with a limited shelf life, once opened and medicines which required cold storage. We were advised of the action taken to resolve some of the recent issues regarding medicine refrigerator temperatures.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessments, the management of medicines on admission, controlled drugs and the storage of medicines.

Areas for improvement

No areas for improvement were identified during this inspection.

	Regulations	Standards
Total number of areas for improvement	0	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 including time critical medicines. Some discrepancies were observed in liquid and inhaled medicines and discussed with staff. An area for improvement was identified.

There were arrangements in place to alert staff of when doses of weekly medicines were due. Reminders were highlighted at the front of the medicines folder and also marked on the medication administration records.

The management of distressed reactions and pain was examined. The medicines were prescribed on the personal medication record and protocols were in place. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour and were aware that this change may be associated with pain. The reason for and outcome of the administration of these medicines was recorded.

We reviewed a number of care plans in relation to medicines management. One resident's care plan required updating in relation to diabetes. An area for improvement was made.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the resident's health were reported to the prescriber.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice included the use of separate administration records for antibiotics and transdermal patches and the use of protocols for medicines prescribed on a "when required" basis. We noted some non-correlation between the personal medication records and the medication administration records medicine entries. To ensure these records correlate, a system should be developed to check the records at the beginning of each medicine cycle. An area for improvement was made.

Practices for the management of medicines were audited throughout the month. This included daily, weekly and monthly audits by staff and management and a quarterly audit by the community pharmacist.

Following discussion with staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to the residents' needs.

Areas of good practice

There were some examples of good practice found throughout the inspection in relation to the administration of medicines and the completion of the medicine records.

Areas for improvement

The administration of inhaled and liquid medicines should be closely monitored.

One resident's care plan should be updated to reflect their current needs.

A system should be developed to ensure that medicine entries on personal medication records and printed medication administration records match.

	Regulations	Standards
Total number of areas for improvement	0	3

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.

We observed the lunchtime medicine round. The residents were encouraged and given time to take their medicines and the medicines were administered as discreetly as possible.

We noted the warm and welcoming atmosphere in the home and the friendly interactions between staff, residents and the residents' representatives. It was evident that there were good relationships and that staff were familiar with the residents' likes and dislikes.

We met with three residents, who expressed their satisfaction with the staff and the care provided. They advised that they were administered their medicines on time and any requests e.g. for pain relief, were met. They stated they had no concerns. Comments included:

"Everything is ok. I'm getting looked after."
"They are very nice here."
"I enjoy it here."
"There's good food all the time."
"I like the chair exercises and the music."
"I enjoy having my own bathroom."

Residents 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.

We met with two relatives who spoke positively about their relatives care. Comments included:

"We are very happy with the care. She has settled well."
"The staff are very nice, we have no concerns at all."

Of the questionnaires which were left in the home to facilitate feedback from residents and their representatives, nine were returned within the specified time frame (two weeks). The responses indicated they were very satisfied/satisfied with the care provided. Two comments were made:

"Everything is very satisfactory."
"I think its lovely here and staff are very nice."

Any further comments in questionnaires received after the return date will be shared with the registered manager as necessary.

Areas of good practice

There was evidence that staff listened to residents and relatives 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 residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents. We were advised that there were arrangements in place to implement the collection of equality data with Dunmurry Manor Residential Care Home.

Written policies and procedures for the management of medicines were in place. A small number of these were spot checked at the inspection. Staff confirmed that there were procedures in place to ensure that they were made aware of any changes.

There were satisfactory arrangements in place for the management of medicine related incidents. Staff knew how to identify and report incidents, and provided details of the procedures in place to ensure that all staff were made aware of incidents and to prevent recurrence. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

The governance arrangements for medicines management were examined. We were informed of the auditing processes completed and how areas for improvement were shared with staff to address and the systems in place to sustain improvement. This included the development of action plans, group supervision and team meetings. A sample of records was provided.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with the registered manager; and any resultant action was discussed at team meetings and/or supervision.

We were advised that there were effective communication systems to ensure that all staff were kept up to date.

The staff we met with spoke positively about their work and advised there were good working relationships in the home and with other healthcare professionals. They were very complimentary regarding the management team and the training provided.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Lisa Gibson, Unit 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 residential care 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 Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

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 QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 33 **Stated:** First time **To be completed by:** 5 October 2018	The registered person shall closely monitor the administration of liquid and inhaled medicines. Ref: 6.5
	Response by registered person detailing the actions taken: Audit tool devised and implemented to monitor and record liquid and inhaled medications.
Area for improvement 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 7 September 2018	The registered person shall update one resident's care plan in relation to diabetes. Ref: 6.5
	Response by registered person detailing the actions taken: Identified careplan reviewed and information updated to include detailed medical information regarding management of diabetes.
Area for improvement 3 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 5 October 2018	The registered person shall develop a system to ensure correlation between personal medication records and medication administration records. Ref: 6.5
	Response by registered person detailing the actions taken: All kardexs rewritten as per GP prescription. Checking system now in place and Medication Lead appointed for pharmacy monitoring to ensure correlation of information between kardex and MARS sheets.

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

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