

# Unannounced Medicines Management Inspection Report 6 April 2017



## Dunlady House

**Type of Service: Nursing Home**  
**Address: 18 Dunlady Road, Dundonald, Belfast, BT16 1TT**  
**Tel no: 028 9048 1002**  
**Inspector: Cathy Wilkinson**

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

## 1.0 Summary

An unannounced inspection of Dunlady House took place on 6 April 2017 from 10.00 to 13.00.

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 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. One area of improvement was identified in relation to care plans for the management of distressed reactions and a recommendation was made.

### **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 share 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.

## 1.1 Inspection outcome

	Requirements	Recommendations
<b>Total number of requirements and recommendations made at this inspection</b>	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Femina Marmeto, 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.

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

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 11 January 2017.

## 2.0 Service details

<b>Registered organisation/registered person:</b> Dunlady House Ltd Mr William Wilson	<b>Registered manager:</b> Mrs Femina Marmeto
<b>Person in charge of the home at the time of inspection:</b> Mrs Femina Marmeto	<b>Date manager registered:</b> 17 February 2016
<b>Categories of care:</b> NH-I, NH-PH, NH-PH(E), NH-TI	<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 one patient, one patient's relative, three registered nurses and the registered manager.

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. One person 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 (MARs)
- 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 11 January 2017

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 their next inspection.

### 4.2 Review of requirements and recommendations from the last medicines management inspection 15 April 2016

There were no requirements or recommendations made as a result of the last medicines management inspection.

### 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 nursing students that the home regularly supervises. 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 and is scheduled again for the coming months.

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. The reason for and the outcome of administration were recorded. A care plan had not been implemented for some patients. This was discussed with the staff and the registered manager. A recommendation was made.

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.

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 extra records for the site of application of transdermal patches and running stock balances for some medicines that were administered on a "when required" basis.

Practices for the management of medicines were audited throughout the month by the staff and management. 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

The registered provider should ensure that care plans for the management of distressed reactions are implemented for the relevant patients. A recommendation was made.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	1
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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.

We spoke to one patient during the inspection. No concerns were raised regarding the management of medicines and the patient stated that they were content and happy in the home and felt safe.

We spoke to one patient's relative who told us that they were very happy with the home and the care provided for their relative. They had no concerns or complaints.

Five patients completed the questionnaire. All of the responses indicated that they were "satisfied" or "very satisfied" with how medicines were managed.

Questionnaires were completed by four patient's relatives. All of the responses indicated that there were no concerns with how medicines were managed in the home.

Some of the comments from relatives included:

"Femy, the manager has been extremely helpful with answering queries that I have had. She has had time to speak to me and (my relatives). I never felt that she was trying to rush me out. She certainly appears to be well respected by her staff."

"(My relative) is receiving the quality and standard of care that she needs and deserves. Medicines and medical care are well managed."

Four members of staff completed the questionnaire and no concerns were raised.

### 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 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.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Femina Marmeto, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 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.

## 5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

## 5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.



### 5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to [pharmacists@rqia.org.uk](mailto:pharmacists@rqia.org.uk) for assessment by the inspector.

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. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.



## Quality Improvement Plan

### Recommendations

#### Recommendation 1

**Ref:** Standard 4

**Stated:** First time

**To be completed by:**  
6 May 2017

The registered provider should ensure that care plans for the management of distressed reactions are implemented for the relevant patients.

**Response by registered provider detailing the actions taken:**

Review of relevant resident medical profile/current condition and prescription was completed. Nursing care plan for management of distressed reactions were implemented. Nursing care plans will be updated and audited at least monthly or as required as the need of the resident arise.

All trained staff advised to identify relevant resident from admission and as the need of the resident changes. Nursing care plan should be implemented to ensure management of distressed reactions of relevant residents.

Policy for management of distressed reaction developed and cascaded down to all trained staff.



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