Unannounced Medicines Management Inspection Report
18 July 2016

Deanfield

Type of Service: Nursing Home
Address: 19 Deanfield, Limavady Road, Londonderry, BT47 6HY
Tel No: 028 7134 4888 / 7134 1754
Inspector: Helen Mulligan

1.0 Summary

An unannounced inspection of Deanfield took place on 18 July 2016 from 9:50 to 14:45.

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?

Some areas of the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff had been trained and deemed competent to administer medicines and the induction process for new staff members included medicines management. Robust procedures were in place for the management of medicines on admission and the management of controlled drugs. Four areas for improvement in relation to the administration of medicines, the competency of staff in charge of the home in the absence of the registered manager, the availability of medicine supplies and the management of limited life medicines were identified. Three requirements and one recommendation were made.

Is care effective?

Some areas of the management of medicines supported the delivery of effective care. Satisfactory arrangements were in place for the management of pain and distressed reactions and the management of swallowing difficulties. Three areas for improvement in relation to the management of personal medication records, the administration of some weekly medicines and the home's procedures for auditing medicines were identified. Two requirements and one recommendation were 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. No areas for improvement were identified.

Is the service well led?

Written policies and procedures for the management of medicines were in place which supported the delivery of care. No areas for improvement were identified during the inspection.

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
Total number of requirements and recommendations made at this inspection	5	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Jenna Nutt, Nurse in Charge of the home as part of the inspection process, and with Mrs Joy McLaughlin, Registered Manager by telephone on 26 July 2016. 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 inspection on 5 July 2016.

2.0 Service details

Registered organisation/registered provider: Loughview Homes Ltd / Mr Michael Curran and Mr Paul Steele	**Registered manager:** Mrs Joy McLaughlin
Person in charge of the home at the time of inspection: Ms Jenna Nutt, Registered Nurse	**Date manager registered:** 13 December 2007
Categories of care: NH-I	**Number of registered places:** 29

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home

Prior to the inspection, it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We spoke with the staff nurse in charge of the home and seven patients.
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
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 5 July 2016

The most recent inspection of the home was an unannounced care inspection. The report of this inspection was issued to the home on 29 July 2016 and the completed QIP will be reviewed by the care inspector when it is returned.

At the last care inspection, a requirement was made regarding the maintenance of pain assessment records in patients' care records. This was reviewed during the medicines management inspection. A sample of patients' care records was examined and it was noted that a record of a completed pain assessment was maintained for each patient.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 2 June 2015

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: **Regulation 13(4)** **Stated: Second time**	The registered manager must review and revise the arrangements for the management of thickened fluids.	**Met**
	Action taken as confirmed during the inspection: The management of a recently prescribed thickening agent was reviewed. Written policies and procedures for the management of thickening agents were in place. An up to date speech and language therapist report was in place for this patient and details of the management of the patient's swallowing difficulties, including the level of thickening of fluids the patients required, were recorded in the patient's care plan. Records of the receipt of thickening agents were maintained. Staff on duty advised that care assistants do not administer thickening agents in the home. The prescription details were not recorded on the patient's personal medication record and records of the administration of thickening agents were not	

	in place. This was addressed during the inspection and staff were reminded that a record of all medicines administered including thickening agents must be maintained. As sufficient progress had been made to address this requirement it was assessed as met.	
Requirement 2 **Ref: Regulation 13(4)** **Stated: First time**	It is a requirement that the registered person must ensure that the admission procedure is robust; any discrepancies between the patient's hospital discharge letter and the medicines supplied on admission must be reviewed in consultation with the prescriber without delay.	**Met**
	Action taken as confirmed during the inspection: The admission process was reviewed for one recently admitted patient and was noted to be robust. No discrepancies were noted.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref: Standard 37** **Stated:** **Second time**	The registered manager should ensure that suitable arrangements are in place to manage the disposal of controlled drugs.	**Met**
	Action taken as confirmed during the inspection: Commercially available kits for denaturing controlled drugs were in place. The majority of records indicated that controlled drugs had been denatured prior to disposal. Staff were reminded that two staff members should sign and verify records of the destruction and disposal of controlled drugs.	
Recommendation 2 **Ref: Standard 38** **Stated:** **Second time**	Two nurses should sign updates to the personal medication record.	**Not Met**
	Action taken as confirmed during the inspection: Where personal medication records had been re-written, these had been signed by two nurses. However, updates to personal medication records had not been signed. A number of improvements in the management of personal medication records were necessary, as detailed in Section 4.4 below. This recommendation has been subsumed into a requirement in Section 4.4.	
Recommendation 3 **Ref: Standard 28** **Stated: First time**	It is recommended that the registered person should ensure a representative sample of medicines in the home, including liquids, inhalers, nebules, topical medicines etc., is included in the home's monthly auditing procedures on a regular basis.	**Not Met**
	Action taken as confirmed during the inspection: A review of medicine audit records showed that only a small number of medicines had been audited since the last inspection, and that only solid dosage form medicines i.e., tablets and capsules had been audited. This recommendation has been stated for the second time.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 4 **Ref: Standard 29** **Stated: First time**	It is recommended that the registered person should ensure insulin doses are recorded as "UNITS" and not "iu" on personal medication records.	**Met**
	Action taken as confirmed during the inspection: Doses of insulin were recorded as "UNITS" on the personal medication records.	
Recommendation 5 **Ref: Standard 28** **Stated: First time**	It is recommended that the registered person should review and revise the management of medicines prescribed for the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: Care plans for the management of distressed reactions were in place and these had been reviewed on a regular basis. Parameters for administration were recorded. No medicines had been required to be administered for some time.	

4.3 Is care safe?

We arrived at the home during the morning medicine administration round. It was noted that the nurse administering the medicines had pre-dispensed a number of patients' medicines into medicine cups. The nurse had signed the record of administration for these medicines before the medicines had been administered. Medicine doses should be prepared immediately prior to their administration from the container in which they are dispensed and the record of administration should be completed once the medicine has been administered. It is unacceptable practice to prepare several patients' medicines in advance of administration. The procedure for administering medicines must be reviewed and revised. A requirement was made.

It was not possible to review records of staff training and competency assessment as the registered manager was on annual leave. Staff on duty advised they had received medicines management training as part of their induction training programme. The nurse in charge of the home was not able to confirm that she had received the appropriate training to manage the home in the absence of the registered manager. This must be addressed. The registered provider must ensure that there is a competent and capable nurse in charge of the home at all times. A requirement was made.

The registered nurse advised of the staff complement on duty during the inspection. This has been referred to the care inspector to follow up.

Staff on duty advised that the impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. This was confirmed by the registered manager on 26 July 2016.
Records of medicines administered highlighted a small number of occasions when medicines had been out of stock. Robust arrangements must be in place to ensure adequate supplies of medicines are available at all times for administration. A requirement was made. Staff were also reminded that RQIA should be notified when medicines have been omitted as a result of stock shortages.

Satisfactory arrangements were not in place to manage changes to prescribed medicines; staff had amended original entries rather than deleting and re-writing a new entry when dosages had changed. Personal medication records had not been updated by two registered nurses. A requirement regarding the maintenance of personal medication records was made in Section 4.4.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and discharge from 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.

Arrangements for the management of high risk medicines were reviewed. A separate record of the administration of insulin was maintained. Blood glucose meters were checked on a regular basis and standard glucose solutions for checking meters were dated when opened. This was good practice. However, an insulin pen in use had not been marked with the date of opening; this was removed for disposal during the inspection and a new pen was brought into use. A recommendation regarding the dating of limited life medicines was made. Supplies of insulin should be monitored and audited on a regular basis. A recommendation regarding the level and scope of medicine audits was stated for the second time in Sections 4.2 and 4.4.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

The medicine storage area was cluttered and untidy. Staff were reminded that the treatment room should be maintained to an appropriate standard for the storage of medicines. The registered manager confirmed by telephone on 26 July 2016 that the medicines storage area had been cleaned and tidied following the inspection.

Some limited life medicines had not been marked with the date of opening and some limited life medicines had been used beyond their expiry date. These were removed for disposal. A recommendation regarding the appropriate management of limited life medicines was made.

Medicine refrigerators have been checked at regular intervals.

The medicine disposal bucket was stored under the desk in the treatment room, the door to which is not always kept locked. Staff were advised that the security of this disposal bucket should be risk-assessed. Following the inspection, the registered manager confirmed that the medicine disposal bucket had been moved to a more secure location in the home.

There were 15 oxygen cylinders stored in the home and tubing used by a previous patient was still attached to the emergency oxygen cylinder. The tubing was removed for disposal during the inspection. The registered manager confirmed by telephone on 26 July 2016 that the excess cylinders had been returned to the supplier. An oxygen concentrator was in use in one patient's bedroom. No signage to indicate oxygen was in use was posted on the patient's door; staff were reminded that this should be addressed.

Areas for improvement

The procedure for administering medicines must be reviewed and revised. A requirement was made.

The registered provider must ensure that there is a competent and capable nurse in charge of the home at all times. A requirement was made.

Robust arrangements must be in place to ensure adequate supplies of medicines are available for administration. A requirement was made.

Limited life medicines should be dated once opened and not used beyond their expiry date. A recommendation was made.

Number of requirements	3	Number of recommendations	1

4.4 Is care effective?

Most of the medicines examined had been administered in accordance with the prescriber's instructions. However, it was noted that doses of some weekly medicines (bisphosphonates) had not been administered. This must be addressed. A requirement was made.

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. A care plan was maintained. Staff advised that it had not been necessary to administer these medicines for a considerable length of time; it was therefore agreed that the management of these medicines would be reviewed in consultation with the prescriber.

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 and this was evidenced during the inspection.

The management of swallowing difficulty was examined. For one patient prescribed a thickening agent, this was not recorded on their personal medication record. This was addressed during the inspection. A requirement regarding the maintenance of personal medication records has been made below. Care plans and speech and language assessment reports were in place.

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.

Improvements were necessary in the maintenance of some medicine records. Amendments to personal medication records were not verified and signed by two nurses. This was disappointing to note as a recommendation regarding the signing of updates to personal medication records was made at the last two medicines management inspections. Dosage changes were not managed appropriately; staff had amended the original entries rather than deleting the old entry and re-writing the new dosage instruction. Where personal medication records had been re-written, the obsolete record had not been clearly discontinued, and signed and dated. Personal medication records must be adequately maintained. A requirement was made.

Staff were reminded that records of the disposal of controlled drugs should be signed by the two members of staff who denature and dispose of them. Records of medicines disposed of comprised loose sheets which were not page numbered and staff were reminded that the security of medicine records must be assured; this was addressed following the inspection and the registered manager advised that these records had been page numbered to improve their security. Staff were also reminded that records of the administration of thickening agents should be maintained.

Some records of medicines ordered and received were incomplete. On a number of occasions, records showed that medicines had been ordered but there was no record that the medicines had been received. Members of staff were reminded that these records must be adequately maintained.

Practices for the management of medicines were audited throughout the month by the staff. However, only a small number of medicines had been audited each month and a representative sample of medicines was not audited; only solid dosage form medicines, i.e. tablets and capsules had been included in the audit process. Systems for recording the running balances of medicines prescribed on a "when required" basis, including paracetamol and co-codamol and weekly medicines were in place but the records were not being adequately maintained. This should be addressed. A recommendation made at the previous medicines management inspection was stated for the second time.

Following discussion with staff, it was evident that when applicable, other healthcare professionals are contacted in response to any medication related issues.

Areas for improvement

Weekly bisphosphonate medicines must be administered as prescribed. A requirement was made.

Personal medication records must be adequately maintained. A requirement was made.

A representative sample of medicines in the home, including liquids, inhalers, nebules, topical medicines etc., should be included in the home's monthly auditing procedures on a regular basis. A recommendation was stated for the second time.

Number of requirements	**2**	**Number of recommendations**	**1**

4.5 Is care compassionate?

The administration of medicines to patients was completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible. Patients advised that they were “really comfortable”, that they “had received their medicines that morning” and that they “would ask staff if they had any pain”. During the inspection, one patient requested pain relief and received their prescribed medication to treat pain without delay.

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.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

Staff confirmed that they knew how to identify and report incidents. No medicine related incidents have been reported since the last medicines management inspection. However, staff had not recognised that incidents involving out of stock medicines should be reported to RQIA (see Section 4.3).

A review of the audit records indicated that largely satisfactory outcomes had been achieved. No significant discrepancies were noted. As detailed in Section 4.4 above, the level of auditing of medicines should be increased.

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. However, the nurse in charge of the home had not received additional training to manage the home in the absence of the registered manager and was unsure of her responsibility regarding two overseas students on placement in the home. The registered manager advised that the nurse designated to be in charge of the home during the registered manager’s absence had been unable to work on the day of the inspection due to sickness. A second registered nurse employed in the home had therefore taken responsibility at short notice. The registered provider must ensure that all staff know their roles and responsibilities in the home, including the management of delegated tasks in the absence of the registered manager. A requirement was made in Section 4.3.

A copy of the QIP from the last medicines management inspection was kept with the home’s written policies and procedures for medicines and staff had signed to say they had read and understood the areas for improvement and the actions to be taken to address these areas. This is good practice. However, not all of the recommendations made at the last medicines

management inspection had been addressed effectively (see Section 4.2 above). In order to drive improvement it was suggested that the QIP should be reviewed on a regular basis.

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.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Jenna Nutt, Registered Nurse in charge of the home, 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 Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The 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 taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to *pharmacists@rqia.org.uk* for review 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

Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 16 August 2016	The registered provider must review and revise the procedures in place for the safe administration of medicines.
	Response by registered provider detailing the actions taken: Discussed at Registered Nurse staff meeting- all issues addressed and supervision carried out
Requirement 2 **Ref**: Regulation 20(3) **Stated:** First time **To be completed by:** 16 August 2016	The registered provider must ensure that there is a competent and capable nurse in charge of the home at all times.
	Response by registered provider detailing the actions taken: All Registered Nurses competencies up dated. Same discussed at staff meeting
Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 16 August 2016	The registered provider must ensure that adequate supplies of prescribed medicines are available for administration.
	Response by registered provider detailing the actions taken: New regime in place for the monitoring of medication. All Registered Nurses aware of same
Requirement 4 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 16 August 2016	The registered provider must ensure that weekly bisphosphonate medicines are administered as prescribed.
	Response by registered provider detailing the actions taken: This is delegated to the night nurses. All made aware at staff meeting
Requirement 5 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 16 August 2016	The registered provider must ensure personal medication records are adequately maintained.
	Response by registered provider detailing the actions taken: This also was discussed at the staff meeting, documentation signed and all aware of the guidelines

Recommendations	
Recommendation 1 **Ref**: Standard 28 **Stated:** Second time **To be completed by:** 16 August 2016	It is recommended that the registered person should ensure a representative sample of medicines in the home, including liquids, inhalers, nebules, topical medicines etc. is included in the home's monthly auditing procedures on a regular basis.
	Response by registered provider detailing the actions taken: New regime put in place. All of the above now audited monthly. Individual nurses delegated residents and responsible for all audits
Recommendation 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 16 August 2016	The registered provider should ensure that limited life medicines are dated once opened and not used beyond their expiry date.
	Response by registered provider detailing the actions taken: Addressed at Registered nurse staff meeting. New practice to ensure the above is addressed

The Regulation and Quality Improvement Authority

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