Unannounced Medicines Management Inspection Report
7 September 2016

Dunmurry Manor

Type of Service: Nursing Home
Address: Rowan Drive, Seymour Hill, Dunmurry, BT17 9PX
Tel No: 028 9061 0435
Inspector: Judith Taylor

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Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Dunmurry Manor took place on 7 September 2016 from 10.00 to 16.15.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence that some elements of the management of medicines promoted the delivery of safe care and positive outcomes for patients. However, areas for improvement were identified. This included training and the disposal of medicines. To ensure that the management of medicines is in compliance with legislative requirements and standards, one requirement and one recommendation have been made.

Is care effective?

A number of areas for improvement were identified and must be addressed to ensure that the management of medicines in this home supports the delivery of effective care. Whilst there was evidence that medicines supplied in the 28 day blister packs had been administered as prescribed, a number of other medicines had not be administered as prescribed and records had not been fully and accurately maintained. Where the administration of medicines was delegated to care staff, there was no records of administration. Improvement is required in the management of patients' pain and medicine changes. The management of skincare must also be reviewed. To ensure that the management of medicines is in compliance with legislative requirements and standards, five requirements and four recommendations have been 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. One relative raised concerns and these were shared with management for follow up. No requirements or recommendations were made.

Is the service well led?

There was limited evidence to indicate that this service was well led. Whilst there were policies and procedures in place, these had not been read and signed by the staff. This had been identified and a new folder had been implemented for this purpose. Systems were in place to enable management to identify and cascade learning from any medicine related incidents. However, in relation to governance arrangements, there was no effective auditing system to ensure that robust arrangements were in place for the management of medicines. One requirement and one recommendation have been made. In considering the findings from this inspection and as requirements have also been made within safe and effective care, this would indicate the need for more robust management and leadership in the home.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 standards until compliance is achieved. Please also refer to section 4.2 and 5.0 of this report.

For the purposes of this report, the term 'patients' will be used to described those living in Dunmurry Manor which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	7	6

At the inspection, details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Joanne Cairns, Acting Manager and Mr Stuart Johnstone, Support Manager. The outcome of the inspection was discussed with Mr John Rafferty, Northern Ireland Operational Director, Runwood Homes Ltd, by telephone on 8 September 2016. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection. However, the outcomes of the inspection resulted in a discussion with the senior pharmacist inspector in RQIA. It was agreed that due to the turnover in managers the Northern Ireland Operational Director of Runwood Homes Ltd would be contacted and advised of the concerns raised. A further inspection will be undertaken to ensure compliance with legislative requirements and professional standards.

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 22–24 June 2016.

2.0 Service details

Registered organisation/registered person: Runwood Homes Ltd/ Mr Nadarajah (Logan) Logeswaran	**Registered manager:** See below
Person in charge of the home at the time of inspection: Ms Joanne Cairns	**Date manager registered:** Ms Joanne Cairns – Acting Manager (no application submitted)
Categories of care: RC-DE and NH-DE	**Number of registered places:** 76

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 two patients, three care staff, one member of senior care staff, three registered nurses, the acting manager, the support manager and one patient's relative.

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.

The following records were 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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 22–24 June 2016

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 6 May 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** Second time	The responsible individual should update the care plan in place to ensure it reflects the roles and responsibilities of care staff in the management of an insulin dependent resident.	**Met**
	Action taken as confirmed during the inspection: The completed QIP stated that this information was recorded in the care plan. There were no residents prescribed insulin in the residential care unit at the time of the inspection. Diabetic awareness training was discussed and the manager advised that this was to be included in the medicines management training programme. Given these assurances this recommendation was assessed as met.	
Recommendation 2 **Ref**: Standard 40 **Stated:** Second time	The responsible individual should ensure, when applicable, that pain assessments are in place.	**Met**
	Action taken as confirmed during the inspection: Pain assessments were in place. Therefore as written this recommendation has been met. However, there were deficits noted in the management of pain and a requirement has been made.	

Recommendation 3 **Ref**: Standard 29 **Stated:** First time	It is recommended that the registered person should review the recording system for medicines prescribed on a "when required" basis for the management of distressed reactions.	**Partially Met**
	Action taken as confirmed during the inspection: These medicines were administered throughout the month for a number of patients. Examination of the records of administration and daily notes for these medicines indicated that the reason for and outcome of the administration was not routinely recorded. This recommendation has been partially met and is stated for a second time.	
Recommendation 4 **Ref**: Standard 4 **Stated:** First time	It is recommended that the registered person should ensure a care plan is maintained for each patient who is prescribed medication for the management of pain.	**Met**
	Action taken as confirmed during the inspection: There was evidence that care plans were maintained for patients who required pain control. Therefore as written this recommendation has been met. However, as mentioned above, deficits in the management of pain were observed and a requirement has been made.	

4.3 Is care safe?

Staff and management confirmed that there was an induction process for registered nurses, agency nurses, senior care staff and care staff. However, records of training were not available. The registered nurses and senior care staff confirmed that they had received training in medicines management. Some care staff stated that training in the management of dysphagia and the administration of external preparations had not been provided. Management advised by email on 8 September 2016 that training in the management of dysphagia and external preparations had commenced and would be completed for all staff by the following week. A requirement regarding training records was made.

Management advised that although there was a process for annual appraisal, assessment of competency and ongoing supervision, this had not been adhered to in recent months, due to the ongoing changes in management. Staff and management advised that there had been a team meeting and areas for improvement in medicines management had been discussed. An action plan regarding the improvements already identified was provided at the inspection and

also details of further action planned in relation to record keeping and training for all staff was provided by email on 8 September 2016.
Although there were systems to manage the ordering of prescribed medicines to ensure adequate supplies were available, it was noted that one medicine had been out of stock in July and was not followed up in a timely manner. It was also noted that a large container of medicines was awaiting disposal, this included currently prescribed medicines. Staff should ensure that any overstocks of medicines are used up before ordering a further supply. It was agreed that this would be reviewed with staff.

The manager advised of the difficulties in obtaining some prescriptions and assured that this was currently being addressed in consultation with the community pharmacist and the prescriber.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. The checks performed on controlled drugs did not identify that some controlled drugs had not been administered as prescribed. Whilst there was a record to assist with audit of Schedule 4 controlled drugs, this had not been fully maintained and the audit trails on these medicines could not be concluded. A requirement regarding an effective audit process was made in section 4.6 and a requirement regarding pain management was made in section 4.4.

Satisfactory arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately. Two staff were not always involved in the disposal of medicines and not all trained staff were aware that Schedule 4 controlled drugs required denaturing. A recommendation was made.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and organised. It was noted that one controlled drug cabinet contained non-medicinal items. It was agreed that these items would be removed and stored securely in a safe.

Some limited shelf life medicines were held in stock. Although the date on the medicine label indicated the medicine was suitable for use, the date of opening was not recorded. This should be recorded to facilitate disposal at expiry. Two medicines had expired and were removed from stock. It was agreed that these issues would be raised with staff. Medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas for improvement

Records which indicate that staff have been trained and deemed competent in the management of medicines must be maintained. A requirement was made.

The disposal of medicines should be reviewed to ensure that robust arrangements are in place. A recommendation was made.

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

4.4 Is care effective?

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. However, a number of discrepancies were found in the audit trails completed on medicines which were not supplied in the 28 day blister packs and there was no evidence that some medicines had been administered as prescribed. A requirement was made.

The evidence seen during the inspection indicated that the management of skin conditions required attention. We observed that one patient required to have his skin care reviewed but this did not appear to have been recognised by the staff despite the patient's apparent discomfort.

The care and medicine records for another patient evidenced that the prescribed external preparations had not been administered in accordance with the directions and that the change in dosage had not occurred. Following discussion with staff, it was concluded that staff were not aware of the prescribed skincare regime. It could not be ascertained how this had impacted the patient. These issues were discussed with management for follow up with the prescriber. A requirement was made.

The administration of time critical medicines such as bisphosphonates was reviewed. Some staff were aware that these must be administered separately from food or medicines. A recommendation was made.

Largely satisfactory arrangements were in place for the management of injectable medicines. A separate administration record had been recently implemented and on most of the patient records, a date for the next dose of injection was recorded. However, at the time of the inspection it could not be clarified if the dose of one monthly injection had been administered as prescribed. On 8 September 2016 the manager confirmed that the injection had been administered and the record completed.

It was noted that improvement was required in the standard of maintenance of the records of prescribing and administration. Several personal medication records were not up to date; there were amended entries and the date of discontinuation of medicines was not always recorded. It was reiterated that these records may be used by other healthcare professionals and must be fully and accurately maintained at all times. A requirement was made. It was acknowledged that a number of personal medication records had been recently rewritten, but were yet to be checked and implemented. A patient photograph was in place for some but not all patients. As agency nurses work in the home, the importance of having a photograph for each patient was emphasised to help ensure medicines are administered safely and to the correct patient. This should be addressed without delay. A recommendation was made.

In relation to administration records, several of these were incomplete, there were unexplained omissions, and for one patient, the dates on the printed medication administration record did not correspond with the date of the current medicine cycle. The administration of medicines by care staff was not routinely recorded i.e. external preparations and the use of thickening agents. A requirement was made.

The management of updating information on medicines records was reviewed. It was advised that any transcribing on personal medication records and medication administration records should involve two members of staff to ensure accuracy. A recommendation 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 fully recorded on the personal medication record for some, but not all of the patients records examined. A care plan was maintained. 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 the administration were not routinely recorded. The recommendation made at the last medicines management inspection was stated for a second time.

The management of pain requires review (see section 4.3). Although a care plan and a pain assessment tool were maintained, the sample of records examined indicated that medicines which were prescribed to manage pain had not always been administered as prescribed. There were instances when the weekly dose of controlled drug patches had been missed on five occasions in the last two months; and regularly prescribed analgesics had not been administered. For two patients, two consecutive doses had not been administered. This was discussed in relation to the management of pain in dementia care. A requirement was made.

The management of swallowing difficulty was examined. For one patient, prescribed a thickening agent, this was not recorded on their personal medication record. In the patient's care folder, two different fluid consistencies were recorded. This was clarified by the registered nurse at the inspection and it was agreed that this would be addressed.

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. The manager provided an example regarding one patient who had been recently reviewed by the prescriber due to ongoing refusal of medicines.

Following discussion with the manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to concerns in relation to medicines management. Details were recorded in a specific section in the care folder.

Areas for improvement

The necessary arrangements must be made to ensure that all medicines are administered in strict accordance with the prescribers' instructions. A requirement was made.

Robust arrangements must be developed for the management of medicine changes to ensure that the prescribed care and treatment is provided to patients to meet their individual needs. A requirement was made.

The administration of bisphosphonate medicines should be reviewed to ensure that all staff are aware of the specific administration instructions; and these medicines are administered in accordance with the manufacturers' instructions. A recommendation was made.

Personal medication records must be kept fully and accurately maintained at all times. A requirement was made.

A recent photograph of each patient should be in place to assist with the safe administration of medicines. A recommendation was made.

The administration of a medicine or reason for any non-administration must be recorded on every occasion. A requirement was made.

Two trained staff should transcribe medicines information on medicine records, and both staff should sign the entry. A recommendation was made.

When a patient is administered a medicine for the treatment of a distressed reaction, a record of the reason for and outcome of the administration should be maintained. A recommendation was stated for a second time.

The management of pain in dementia care must be reviewed. Systems must be developed to ensure that each patient's pain is well controlled. A requirement was made.

Number of requirements	5	Number of recommendations	4

4.5 Is care compassionate?

The administration of medicines to patients was observed at the inspection. Medicines were administered in a caring manner; the patients were given time to take their medicines and medicines were administered as discreetly as possible.

The patients spoken to at the inspection advised that they had no concerns regarding the management of their medicines and confirmed that staff generally responded to their requests for medicines in a timely manner. One patient advised he was still waiting on pain relief that had been requested earlier that morning. This was discussed with management for follow up.

The patients were also complimentary about the staff and comments included:
"I get great attention from the staff."
"Food is excellent."
"I love it here, it's great."

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.

One visitor met with the inspector and raised concerns regarding the care of their relative. The visitor was in agreement that these concerns would be shared with management during the inspection. These concerns were shared with management and the registered provider.

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?

The inspection findings in relation to safe and effective care evidence that the management of medicines has not been well led and this has had an impact on the delivery of care. This was discussed at length and management provided assurances that the areas identified would be addressed. Initial details of the actions to be taken were provided by email and also by telephone on 8 September 2016.

Written policies and procedures for the management of medicines were in place. The manager had identified that these had not been read by staff and this process had commenced.

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.

The previous medicines management inspection evidenced that personal medication records and medicine administration records were maintained accurately. It also evidenced that a medicines auditing system was in place which covered all aspects of the management of medicines. There was little evidence that these standards had been sustained through the recent changes in management. There was no oversight of the systems in place for the management of medicines. Several audit trails could not be concluded as the date of opening and/or the quantity of medicine carried forward to the new medicine cycle was not recorded. This is best practice and should be implemented. A recommendation was made. As there were some discrepancies in the audit trails and areas for improvement were identified in relation to training, the standard of record keeping and governance arrangements, an auditing system which covers all aspects of medicines management must be developed and implemented. A requirement was made.

Following discussion with the manager, registered nurses and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Not all of the recommendations made at the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff at handover and at team meetings.

Areas for improvement

All staff managing medicines should ensure that the date and time of opening is recorded on medicines which are not supplied in the 28 day packs; and also record the quantity of medicine carried forward to the next medicine cycle. A recommendation was made.

A robust auditing process must be developed and implemented; this must cover all aspects of medicines management and ensure there is a system in place to follow up any areas identified for improvement. A requirement was made.

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

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Joanne Cairns, Acting Manager, Mr Stuart Johnstone, Support Manager, and Mr John Rafferty, Northern Ireland Operational Director, 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 the **web portal** 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

Statutory requirements	
Requirement 1 **Ref**: Regulation 19(2) **Stated:** First time **To be completed by:** 7 October 2016	The registered provider must ensure that there are records which indicate that staff are trained and competent in the work that they perform.
	Response by registered provider detailing the actions taken: All staff who have responsibility for administration of medication are having their competencies renewed and records will be retained for inspection
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 7 October 2016	The registered provider must ensure that all medicines are administered in strict accordance with the prescriber's instructions.
	Response by registered provider detailing the actions taken: As part of tutoring staff in medicine competencies all staff will be informed that they must administer medications as prescribed. A new medication system has been brought in, through a new supplier, which will improve the current system in place
Requirement 3 **Ref:** Regulation 12(1) **Stated:** First time **To be completed by:** 7 October 2016	The registered provider must make the necessary arrangements to ensure that robust arrangements are in place to manage medicine changes.
	Response by registered provider detailing the actions taken: A new protocol is being developed to alert medication changes with the registered manager and the person in charge of the shift
Requirement 4 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 7 October 2016	The registered manager must ensure that personal medication records are fully and accurately maintained at all times.
	Response by registered provider detailing the actions taken: All staff need to complete medicine records adhering to their professional code of conduct. Disciplinary action will be commenced against any staff meember who fails to follow correct procedure
Requirement 5 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 7 October 2016	The registered provider must ensure that a record of the administration or non-administration of a medicine is maintained on every occasion.
	Response by registered provider detailing the actions taken: This area of practice has been reinforced to all members of staff who administer medication. Staff records will be monitored for adherence to this requirement

Requirement 6 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 7 October 2016	The registered provider must ensure that there are robust arrangements in place for the management of patient's pain.
	Response by registered provider detailing the actions taken: The Abbey pain scale will be put in place for all residents and wound care audits have been completed for all residents in the home
Requirement 7 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 7 October 2016	The registered provider must develop a robust system to audit all aspects of medicines management and ensure that any areas for improvement are followed up.
	Response by registered provider detailing the actions taken: Audited medications, and compliance for best practice will be completed regularly and lessons learned will be used to improve practices
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** Second time **To be completed by:** 7 October 2016	It is recommended that the registered person should review the recording system for medicines prescribed on a "when required" basis for the management of distressed reactions.
	Response by registered provider detailing the actions taken: A new audit tool for distressed reactions medication is developed and will be implemented in full on a regular basis. Copies will be available for inspection
Recommendation 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 7 October 2016	The registered provider should there are robust arrangements in place for the disposal of medicines.
	Response by registered provider detailing the actions taken: Robust arrangement has been put in place for disposal of medications
Recommendation 3 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 7 October 2016	The registered provider should make the necessary arrangements to ensure that bisphosphonate medicines are administered in accordance with the manufacturers' instructions.
	Response by registered provider detailing the actions taken: The requirement to administer these medications, staff must adhere to manufactures' recommended instructions

Recommendation 4 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 7 October 2016	The registered provider should ensure that a recent photograph of each patient is available to facilitate the safe administration of medicines.
	Response by registered provider detailing the actions taken: This has been implemented already, all residents have current up to date photograph on both their Medicine Kardex and Care Plans
Recommendation 5 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 7 October 2016	The registered provider should ensure that two trained staff are involved in the transcribing of medicines information on medicine records; both staff should initial the entry on every occasion.
	Response by registered provider detailing the actions taken: This recommendation will be compulsory within the home
Recommendation 6 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 7 October 2016	The registered provider should ensure that the date and time of opening are recorded on all medicines to facilitate removal once the expiry date is reached and for audit purposes.
	Response by registered provider detailing the actions taken: This recommendation will also be made compulsory within the home

Please ensure this document is completed in full and returned to the web portal

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