Inspection Report
14 September 2020

Oak Tree Manor Nursing Home

Address: 2A Hazel Avenue, Dunmurry, Belfast, BT17 9QU
Tel No: 028 9061 0435
Inspector: Judith Taylor

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 this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a nursing home which is registered to provide care for up to 24 patients living with a diagnosis of dementia. It is situated in the same building as Oak Tree Manor Residential Home.

2.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Mr Gavin O'Hare-Connolly	**Registered Manager and date registered:** Ms Michelle Montgomery 11 March 2020
Person in charge at the time of inspection: Mr Tiago Moreira (Support Manager)	**Number of registered places:** 24
Categories of care: Nursing Home (NH): DE - Dementia	**Total number of patients in the nursing home on the day of this inspection:** 15

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 14 September 2020 from 10.30 to 14.30. Short notice of the inspection was provided on the morning of the inspection in order to ensure that arrangements could be made to safely facilitate the inspection in the home.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the last medicines management inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to staff and the support manager about how they plan, deliver and monitor the care and support provided in the home
- observed staff interactions with patients
- reviewed documents to confirm that appropriate records were kept

A sample of the following was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drugs records
- care plans related to medicines management regarding patients who were prescribed medicines for distressed reactions, pain and a modified diet
- governance and audit for medicines management
- staff training and competency for medicines management
- medicine storage temperatures

4.0 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 Mr Tiago Moreira, Support 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.

5.0 What has this service done to meet any areas for improvement identified at the last care inspection on (21 and 22 August 2020) and the last medicines management inspection (8 November 2018)?

The most recent inspection of the home was an unannounced care inspection undertaken on 21 and 22 August 2020. The report from this inspection had not been issued at the time of this inspection. Any areas for improvement identified will be reviewed at a future care inspection.

No areas for improvement were identified at the last medicines management inspection.

6.0 What people told us about this service?

Patients were relaxing in their bedrooms or in the lounges watching television. A small number of patients liked to sit beside the nursing station and enjoyed interactions with the staff.

Staff were warm and friendly and it was evident from their interactions that they knew the patients well.

We met with two registered nurses and the support manager. The support manager had recently been appointed to the home. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed. Staff said that they had the appropriate training to look after patients and meet their needs; and were very familiar with their roles and responsibilities within the organisation and the home. They advised that they felt supported in their work and were very complimentary regarding the management team.

Feedback methods included a staff poster and paper questionnaires which were provided for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no questionnaires had been received by RQIA.

7.0 Inspection findings

7.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs will change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, medical consultant or the pharmacist.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, medication reviews or hospital appointments.

The majority of the personal medication records reviewed at the inspection were accurate and up to date. In line with safe practice, a second member of staff had checked and signed the personal medication records when they were written and updated to ensure that they were accurate. However, we noted that a small number of records required updating. This was addressed by the registered nurse during the inspection. A system should be in place to ensure that these records are checked regularly for accuracy. See Section 7.3.

Copies of patients' prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription. This is best practice.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, diabetes, pain, modified diets etc.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason why it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Care plans were in place. 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. Directions for use should be clearly recorded on the personal medication records to ensure staff know the frequency of use and the maximum daily dose which can be administered. We noted that full dosage directions were not recorded for some patients. The reason for the administration was recorded on some occasions; but the outcome was not recorded. This management of medicines prescribed for distressed reactions, was identified as an area for improvement.

We reviewed the management of medicines prescribed to manage diabetes, for example insulin. The medicine records were well maintained and a care plan was in place. See also Section 7.2.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Pain management care plans and assessments were maintained and detailed the medicines prescribed.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

We reviewed the management of thickening agents. Speech and language assessment reports and care plans were in place. Records of prescribing and administration, which included the recommended consistency level of fluids, were maintained. In relation to food supplements, records indicated that these had been administered as prescribed; however, we were unable to complete audits and there was no evidence that this area of medicines management was included in the audit process. See also Section 7.6.

Some patients cannot swallow medicines very well and occasionally medicines may require to be crushed to help the patient take their medicines. This applied to a small number of patients and was detailed on their medicine labels. It was agreed that this detail would be added to the patients' care plans following the inspection.

7.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error. A record of all incoming medicines and outgoing medicines must be maintained.

With the exception of one medicine, the records inspected showed that medicines were available for administration when patients required them. One patient missed two doses of a medicine as there was no stock available; this had been followed up appropriately. However, it had not been reported to RQIA; this appears to have been an oversight. This notification was sent to RQIA following the inspection.

The medicines storage areas, including the medicine trolleys, controlled drug cabinet and medicines refrigerator were observed to be securely locked to prevent any unauthorised access. They were clean, tidy and well organised so that medicines belonging to each patient could be easily located. However, we identified two unlabelled in-use insulin pen devices, stored in the medicine refrigerator; the date of opening was not recorded. Opened insulin pen devices must be stored in accordance with the manufacturer's instructions and in this case they should be stored at room temperature after opening. As these are limited shelf life medicines, the date of opening must be recorded to ensure that they are replaced when the expiry date has been reached. This was addressed by the registered nurse during the inspection. This is an area that should be included in the audit process. See also Section 7.6.

We reviewed the disposal arrangements for medicines. A record of all discontinued medicines was maintained. This record provides evidence that the home is no longer responsible for the medicines and also facilitates the audit process. To ensure robust systems are in place for disposal, two staff should be involved in the disposal and both staff should sign the disposal record. Where there are controlled drugs awaiting disposal, those in Schedules 2, 3 and 4 (Part 1) must be destroyed before they are put in the waste disposal bin, and this should be noted on the disposal records. These records were signed by two staff, but there was no evidence that all controlled drugs in Schedule 4 (Part 1) were destroyed prior to disposal. The disposal of medicines was identified as an area for improvement.

7.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed and they indicated that medicines were being administered as prescribed. Handwritten entries were routinely signed by two nurses to ensure accuracy. This is safe practice. Staff were reminded that where a variable dose is prescribed, for example

10ml or 20ml, the actual quantity administered must be recorded on every occasion. It was agreed that this would be reviewed within the audit process. See Section 7.6.

In relation to topical medicines, examination of current records did not evidence that all topical medicines had been administered as prescribed. We discussed the current process and gave advice. This was identified as an area for improvement.

Management and staff audited medicine administration on a regular basis within the home. This is necessary to ensure that robust systems are in place for the safe management of medicines and also to ensure that the patient has been administered their medicines. The date of opening was recorded on most medicines so that they could be easily audited. Staff had also recorded daily stock balances for the majority of oral medicines, which were not supplied in the monitored dosage system; this enabled staff to identify if there were any errors. Staff had also recorded the stock balance of medicines that were carried over for use in the next medicine cycle. These are areas of good practice.

The majority of audits completed during this inspection showed that medicines had been administered as prescribed. However, we identified three discrepancies in liquid medicines and noted that liquids medicines were not routinely audited. See also Section 7.6.

7.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

We discussed the admission process for patients new to the home or returning to the home after receiving hospital care. Staff advised that robust arrangements were in place to ensure that they were provided with written confirmation of the patient's medicine regime and this was shared with the community pharmacist. We reviewed one patient's records and there was evidence that the appropriate information had been obtained and recorded.

7.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicine incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. These had been managed appropriately. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence. See also Section 7.1.

7.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported to do this.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments. Records of staff training in relation to medicines management were maintained.

In addition to training of staff, robust governance and audit processes should be in place to ensure the safe management of medicines. These processes should be effective in determining if the system is running well or requires review. Although the inspection findings indicated patients were receiving their medicines, shortfalls were identified in other areas of medicines management as detailed in the report. The audit processes should be developed to include all areas of medicines management and these should be monitored on a regular basis. This was identified as an area for improvement.

8.0 Evaluation of Inspection

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the service was well led with regard to the management of medicines.

Whilst we identified areas for improvement, we can conclude that overall, the patients were being administered their medicines as prescribed.

We would like to thank the patients and staff for their assistance throughout the inspection.

9.0 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 Mr Tiago Moreira, Support Manager, as part of the inspection process. The timescales commence from the date of inspection.

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

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

9.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Care Standards for Nursing Homes (2015).

9.2 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 the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health Care Standards for Nursing Homes (2015)	
Area for improvement 1 **Ref**: Standard 18 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall review the record keeping in relation to distressed reactions to ensure that dosage directions are fully recorded on personal medication records and the reason for and outcome of each administration are recorded. Ref: 7.1
	Response by registered person detailing the actions taken: Records for medication administered to manage distressed reactions is now recorded on our digital record system with details regarding reason for administration, medication administered and dose as well as effectiveness
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall make the necessary arrangements to ensure that disposal of medicines records are fully maintained; and clearly indicate that all controlled drugs in Schedule 4 (Part 1) have been denatured prior to disposal by two trained staff. Ref: 7.2
	Response by registered person detailing the actions taken: Arrangements have been made and the disposal of all medicines is carried out as per guidelines and all Schedule 4 (Part 1) drugs are denatured by two staff members
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall develop an effective audit process which includes all formulations of medicines and covers all areas of medicines management. Ref: 7.6
	Response by registered person detailing the actions taken: **Audit process is implemented and ensures that all areas of medicines management are audited, including all formulations od medicines**

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

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