Unannounced Medicines Management Inspection Report
21 November 2016

Daisyhill Private Nursing Home

Type of Service: Nursing Home
Address: 50a Ahoghill Road, Randalstown, BT41 3DG
Tel No: 028 9447 9955
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Daisyhill Private Nursing Home took place on 21 November 2016 from 10.30 to 14.50.

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.

This was the first medicines management inspection following the transfer of ownership to Town and Country Care Homes Limited on 8 July 2016.

Is care safe?

There was evidence that some areas of the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines had been provided with training and had been deemed competent. Four areas for improvement were identified in relation to the management of two medicines, the management of controlled drugs, records of disposal and recording dates of opening. One requirement and three recommendations were made.

Is care effective?

There was evidence that some areas of the management of medicines supported the delivery of effective care. Four areas for improvement were identified. Two requirements and two recommendations were made. One of the requirements and one of the recommendations were stated for the second time.

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 of improvement identified.

Is the service well led?

Areas for improvement in this domain were discussed with the registered person and assurances were provided that corrective action had already commenced. Written policies and procedures for the management of medicines were being updated. Plans were in place to implement a robust audit tool. Guidance on the management of incidents and their reporting was provided. No requirements or recommendations were made.

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	3	5

Details of the Quality Improvement Plan (QIP) within this report were discussed with Dr Marina Lupari, Registered Person, and Mrs Mary Taylor, Registered Nurse, during the inspection. 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 12 September 2016.

2.0 Service details

Registered organisation/registered person: Town & Country Care Homes Ltd Dr Marina Lupari	**Registered manager:** Miss Colleen McWilliams
Person in charge of the home at the time of inspection: Dr Marina Lupari (until 12.30) Mrs Mary Taylor (12.30 onwards)	**Date manager registered:** 29 October 2015
Categories of care: NH-LD, NH-LD(E)	**Number of registered places:** 25

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 individually, and greeted several other patients throughout the day, one senior carer, one registered nurse and one of the registered persons.

As part of the inspection process a number of questionnaires were issued to patients, relatives/patients' representatives and staff, with a request that they were returned within one week from the date of the inspection.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 12 September 2016

The most recent inspection of the home was an announced care inspection. The 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 23 July 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person must ensure that records of the administration of external preparations by designated care staff are accurately maintained.	**Not Met**
	Action taken as confirmed during the inspection: Care staff were responsible for the administration of emollient preparations only. They confirmed that records were no longer being maintained. This requirement was stated for a second time.	
Requirement 2 **Ref:** Regulation 20 (1) **Stated:** First time	The registered person must ensure that training in delegated medicines tasks, such as the administration of external preparations and thickening agents, is provided for designated care staff and that records are maintained.	**Met**
	Action taken as confirmed during the inspection: The registered person confirmed that this now forms part of the induction process and that records were maintained. These were not available for inspection as the registered manager was not on duty. Due to the assurances provided by the registered person this requirement was not restated.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 28 **Stated:** First time	It is recommended that update training is provided for relevant staff on the management of enteral feeding tubes including the administration of medicines via this route.	**Met**
	Action taken as confirmed during the inspection: The registered person and registered nurse confirmed that training had been provided by the Trust in recent months.	
Recommendation 2 **Ref**: Standard 28 **Stated:** First time	It is recommended that records of competency assessments for registered nurses and for those care assistants responsible for delegated medicines tasks are maintained.	**Met**
	Action taken as confirmed during the inspection: The registered person confirmed that the competency assessments had been completed following the last medicines management inspection. Records were not available for inspection as the registered manager was not on duty. The registered person advised that going forward plans were in place for the senior care assistant to take responsibility for carrying out competency assessments with care assistants.	
Recommendation 3 **Ref**: Standard 4 **Stated:** First time	It is recommended that care plans for the management of pain should be in place and reviewed regularly where analgesia is prescribed, to include guidance for staff on how pain may be expressed by individual patients.	**Not Met**
	Action taken as confirmed during the inspection: A review of a sample of care records indicated that these care plans were not in place. This recommendation was stated for a second time.	

4.3 Is care safe?

The registered person confirmed that 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 care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Training on the management of medicines had been provided by the supplying pharmacist in July 2016. Registered nurses had also received training on enteral feeding within the last year. Epilepsy awareness training is planned for the end of November 2016.

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 were updated by two registered nurses. This safe practice was acknowledged. However, for one patient who was prescribed two medicines to be administered on an alternating basis it could not be ascertained which medicine was currently being administered. Both medicines were available for administration and both had been signed as administered on most nights from 13 November 2016. The registered person was requested to ensure that the correct medicine was being administered from the day of the inspection onwards and this was confirmed via a telephone call after the inspection. An investigation and an action plan to prevent a recurrence were requested. A requirement was made.

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. Staff were reminded that discontinued controlled drugs should be included in the stock handover checks until they are denatured and disposed of. In accordance with recognised safe practice the administration of controlled drugs should be witnessed by a trained and competent member of staff. This was not the current practice in the home. The registered person should review and revise the management of controlled drugs. A recommendation was made.

Satisfactory arrangements were observed for the management of medicines via the enteral route. Daily feeding regimens were in place and fluid intake charts were being maintained.

Discontinued or expired medicines were disposed of appropriately. The registered person confirmed that discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. Two registered nurses should be involved in the disposal of medicines and both should sign the entry in the disposal record book. 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 well organised. Medicine refrigerators and oxygen equipment were checked at regular intervals. Dates of opening had not been recorded on all medicines, including limited shelf life medicines. This meant that medicines could have been in use after their expiry date and audit trails could not be completed to evidence that the medicines had been administered as prescribed.

The registered person should ensure that dates of opening are recorded on all medicines to facilitate audit and disposal at expiry. A recommendation was made.

Areas for improvement

The registered person must investigate the discrepancy highlighted at this inspection. A report of the investigation and the action taken to prevent a recurrence must be forwarded to RQIA. A requirement was made.

The registered person should review and revise the management of controlled drugs. A recommendation was made.

The registered person should ensure that two registered nurses sign the records of disposal. A recommendation was made.

The registered person must ensure that dates of opening are recorded on all medicines to facilitate audit and disposal at expiry. A recommendation was made.

Number of requirements	1	Number of recommendations	3

4.4 Is care effective?

The majority of medicines examined had been administered in accordance with the prescriber's instructions. However, audits on some medicines could not be completed as dates of opening had not been recorded.

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. Care plans were in place but they were incomplete as they did not reference any prescribed medication. 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 several patients could not verbalise their pain. Pain assessment tools were not in use. The registered person advised that registered nurses and care staff were familiar with the patients and would be aware that if their behaviours changed they may be in pain. Care plans were not in place. Care plans for the management of pain should be in place and reviewed regularly where analgesia is prescribed. The care plans should include guidance for staff on how pain may be expressed by individual patients. A recommendation was stated for the second time.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Care plans and speech and language assessment reports were in place. Registered nurses recorded administration on the medication administration records. However, care staff did not record administration. A requirement was made.

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

With the exception of the administration record highlighted in section 4.3, the majority of medicine records were well maintained and facilitated the audit process. However, as identified at the last medicines management inspection, records for the administration of external medicines by care staff were not being maintained. A requirement was stated for the second time.

Medicines were supplied in weekly compliance aids which meant that any discrepancy in the administration of these medicines was evident at the end of each week. Medicines which were not supplied weekly were not being audited. The registered person advised that a comprehensive audit tool was currently being developed. As detailed in section 4.3, the date of opening had not been recorded on several medicines and this must be addressed to facilitate the audit process and disposal at expiry.

Following discussion with the registered person and registered nurse, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas for improvement

The registered person must ensure that records of the administration of external preparations by designated care staff are accurately maintained. A requirement was stated for the second time.

Care plans for the management of pain should be in place and reviewed regularly where analgesia is prescribed. The care plans should include guidance for staff on how pain may be expressed by individual patients. A recommendation was stated for the second time.

The registered person must ensure that care staff record the administration of thickening agents. A requirement was made.

The registered person should ensure that details of any prescribed medicines are recorded in care plans for the management of distressed reactions when appropriate. A recommendation was made.

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

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.

We spoke with one patient who confirmed that they were happy with the care provided by the staff and how their medicines were managed.

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.

As part of the inspection process a number of questionnaires were issued to patients, relatives/patients' representatives and staff, with a request that they were returned within one week from the date of the inspection. Three patients completed and returned the questionnaires. The responses were positive and these were recorded as "satisfied" or "very satisfied" with regard to the management of medicines in the home.

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?

Policies and procedures for the management of medicines were being updated. Staff still had access to the current policies and procedures.

Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. Although there was evidence of the action taken and learning implemented following incidents this had not been detailed in the incident report forms. The registered person was reminded that incident report forms should include details of the learnings identified and action taken to prevent a recurrence of the incident.

Following discussion with the registered person, the registered nurse and senior carer, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. The evidence seen during the inspection highlighted that care staff do not always document any actions they take when tasks are delegated to them (see section 4.4).

Not all of the requirements and 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 either individually or via team meetings.

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 the QIP were discussed with Mrs Mary Taylor, Registered Nurse, on the day of the inspection and with Dr Marina Lupari, Registered Person, via telephone call, 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 via 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 13 (4) **Stated:** Second time **To be completed by:** 21 December 2016	The registered person must ensure that records of the administration of external preparations by designated care staff are accurately maintained.
	Response by registered provider detailing the actions taken: New system introduced based on topical administration kardex to be delegated and signed by Care Assistants. Training in place to enable Care Assistants to gain the required competencies to enable them to competently complete this task. Audit process introduced to enable Registered Nurses to be satisfied that this is being completed.
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 21 December 2016	The registered person must investigate the discrepancy highlighted at this inspection. A report of the investigation and action taken to prevent a recurrence must be forwarded to RQIA.
	Response by registered provider detailing the actions taken: Investigation was delayed due to staff related sickness. Commenced 09th Jan 2017. Investigation report being finalised and will be submitted to RQIA by 31st January 2017.
Requirement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 21 December 2016	The registered person must ensure that care staff record the administration of thickening agents.
	Response by registered provider detailing the actions taken: New system in place through the use of a new supplements kardex. Training in place to enable Care Assistants to gain the required competencies to enable them to competently complete this task. Audit process introduced to enable Registered Nurses to be satisfied that this is being completed. Recording for fluids will be undertaken via the Regional fluid Balance chart
Recommendations	
Recommendation 1 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 21 December 2016	It is recommended that care plans for the management of pain should be in place and reviewed regularly where analgesia is prescribed, to include guidance for staff on how pain may be expressed by individual patients.
	Response by registered provider detailing the actions taken: As an ongoing review of care plans for all residents this will be introduced and led by Director of Care. A distressed care plan based on the DISDAT and Abbey Pain assessment tool is being introduced. Special consideration is being given to people with Learning Disability and dementia

Recommendation 2 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 21 December 2016	The registered person should review and revise the management of controlled drugs.
	Response by registered provider detailing the actions taken: A series of work streams have been undertaken by Director of Care in terms of the reissuing of SOPs for Controlled Drugs, all relevant NMC documentation and Policies for all aspects of Medication Management. This is the the policy theme for February for Town & Country Care Homes Ltd. A safe Custody Drug log introduced for all schedule 3 and 4 drugs. An agenda item for forthcoming staff nurses meeting Monday 30th Jan 2017. An audit system has been introduced that will be led by Deputy Manager.
Recommendation 3 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 21 December 2016	The registered person should ensure that two registered nurses sign the records of disposal of medicines.
	Response by registered provider detailing the actions taken: New SOP and policy issued by Director of Care. This is now in place and all Registered Nurses informed of this process. An audit system has been introduced by Director of Care that will be led by Deputy Manager.
Recommendation 4 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 21 December 2016	The registered person must ensure that dates of opening are recorded on all medicines to facilitate audit and disposal at expiry.
	Response by registered provider detailing the actions taken: This is now in place and all Registered Nurses informed of this process. Label now available to be applied routinely. An audit system has been introduced by Director of Care that will be led by Deputy Manager.
Recommendation 5 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 21 December 2016	The registered person should ensure that the details of any prescribed medicines are recorded in care plans for the management of distressed reactions when appropriate.
	Response by registered provider detailing the actions taken: Staff training in place. As an ongoing review of care plans for all residents this will be introduced. A distressed care plan based on the DIASDAT and Abbey Pain assessmnet tool is being introduced. Special consideration is being given to people with Learning Disability and dementia. An audit system has been introduced by Director of Care that will be led by Manager/Deputy Manager.

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