Unannounced Medicines Management Inspection Report
12 October 2017

Glenkeen House

Type of Service: Nursing Home
Address: 100 Glenkeen Church Road, Randalstown, BT41 3JX
Tel No: 028 9447 9794
Inspector: Rachel Lloyd

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 40 beds that provides care for patients living with a range of healthcare needs (see section 3.0).

3.0 Service details

Organisation/Registered Provider: Hutchinson Homes Ltd **Responsible Individuals:** Mrs Janet Montgomery & Ms Naomi Carey	**Registered Manager:** Mrs Jacqueline Elizabeth McShane
Person in charge at the time of inspection: Ms Preshela Baguio (Registered Nurse)	**Date manager registered:** 1 April 2005
Categories of care: Nursing Homes (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment Residential Care Homes (RCH) I – Old age not falling within any other category MP(E) – Mental disorder excluding learning disability or dementia – over 65 years PH(E) – Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 40 The home is also approved to provide care on a day basis to 5 persons.

4.0 Inspection summary

An unannounced inspection took place on 12 October 2017 from 09.50 to 14.15.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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.

The terms ‘patients’ will be used to describe those living in Glenkeen House which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified during and since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staff training, record keeping and care planning, the management of controlled drugs and the relationships between staff and their knowledge of the patients and their needs.

Areas requiring improvement were identified in relation to ensuring that all prescribed medicines are available for administration, that the accuracy of personal medication records is checked appropriately, and that all medicines are stored at the correct temperature.

The patients and one relative spoken to were complimentary regarding the care provided in the home.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	3

Details of the Quality Improvement Plan (QIP) were discussed with Ms Preshela Baguio, Registered Nurse, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions required to be taken following the most recent inspection on 14 September 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

- 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.

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection we met with two patients, one relative and two registered nurses including the nurse in charge.

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
- care plans
- training records
- medicines storage temperatures
- policies and procedures

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

Areas for improvements identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 14 September 2017

The most recent inspection of the home was an unannounced care inspection. The report was issued and the completed QIP will be returned and will be assessed by the care inspector. This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 31 August 2016

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time	The registered provider should ensure that the management of bisphosphonate medicines is reviewed to ensure that medicine records accurately reflect the time of administration.	**Met**
	Action taken as confirmed during the inspection: Medicine records examined and discussion with registered nurses indicated that medicine records accurately reflected the time of administration of these medicines.	

Area for improvement 2 **Ref**: Standard 18 **Stated:** First time	The registered provider should ensure that the reason for and the outcome of administration of medicines administered on a 'when required' basis for the management of distressed reactions is recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: Examination of records and discussion with registered nurses indicated that there were no recent examples of these medicines being administered on a 'when required' basis. However, it was confirmed that these details are recorded in the patient's daily notes on every occasion they are administered. Due to these assurances this area for improvement was assessed as met.	
Area for improvement 3 **Ref**: Standard 30 **Stated:** First time	The registered provider should ensure that the date of opening is recorded on all medicines to facilitate the audit process.	**Met**
	Action taken as confirmed during the inspection: The date of opening was recorded on all medicines examined.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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. Refresher training in medicine management was provided in February 2017. The most recent training was in relation to the management of medicines using a syringe driver in July 2017.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

Systems to manage the ordering of prescribed medicines to ensure that adequate supplies were available were reviewed. Antibiotics and newly prescribed medicines had been received into the home and administered promptly. However, four examples of medicines being omitted in the three days prior to the inspection due to being out of stock were observed. One of these was available in the overstock cupboard and the others were either back in stock after one missed dose, or were ordered and due to be received that day. Although it was acknowledged that action had been taken once registered nurses were aware that a medicine was out of stock, systems need to be reviewed to ensure that all medicines are available for administration as prescribed. An area for improvement was identified.

The arrangements in place to manage changes to prescribed medicines were examined. Personal medication records were mostly checked and signed by two registered nurses, however some had not been double checked for accuracy, including those for recently admitted patients. New entries to personal medication records had not been checked and signed for accuracy by two registered nurses. An area for improvement was identified. There were otherwise satisfactory 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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged. This is good practice.

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

Medicines were largely stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. However, the radiator in the treatment room was on and the temperature in the room was not being monitored. The storage temperature of medicines should be monitored on a daily basis to ensure it does not exceed the maximum storage temperature of 25◦C. Medicine refrigerator temperature records indicated that the thermometer was not being reset daily when temperatures were recorded. This had been discussed at the last medicines management inspection and needs to be reviewed. Two areas for improvement were identified. Oxygen equipment was stored appropriately and checked at regular intervals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, the management of controlled drugs and the disposal of medicines.

Areas for improvement

Areas for improvement were identified in relation to reviewing procedures to ensure that all medicines are available for administration as prescribed, reviewing the management of personal medication records to ensure accuracy in transcription, monitoring the temperature of the medicine storage area and the management of the medicine refrigerator temperature.

	Regulations	Standards
Total number of areas for improvement	1	3

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The sample of medicines examined had mostly been administered in accordance with the prescriber's instructions. A few minor discrepancies were highlighted to staff for attention. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff as to when doses of weekly, monthly or three monthly medicines were due.

The management of distressed reactions, swallowing difficulty and pain were reviewed. The relevant information was recorded in the patient's care plan, personal medication record and records of administration.

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

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. These included the use of supplementary sheets for the administration of transdermal opioid patches, warfarin, insulin and antibiotics. A care plan was also in place for patients prescribed an antibiotic.

Practices for the management of medicines were audited by the staff and management. In addition, audits were completed by the community pharmacist.

Following discussion with the registered nurses, it was evident that other healthcare professionals are contacted when required to meet the needs of patients.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, care planning, the administration of medicines and audit procedures.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The administration of medicines to patients was observed. It was completed in a caring manner and patients were given time to take their medicines.

Patients spoken to were content and relaxed in the home. The patients and one relative spoken to were complimentary regarding the care provided in the home and the prompt medical care received when necessary. 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. Staff demonstrated a good knowledge of patients' wishes and preferences.

At the time of issuing this report three questionnaires had been returned from patients, two from relatives and five from members of staff who advised that they were satisfied/very satisfied with all aspects of the care in relation to the management of medicines.

Areas of good practice

There was evidence that staff listened to and valued patients and took account of their views. Good relationships were observed between staff and patients.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

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 them.

The arrangements in place for the management of medicine related incidents were examined. Registered nurses 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. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team. It was discussed and agreed that any further omission of prescribed medicines due to them being out of stock needs to be reported to RQIA.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the registered nurses, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with management. Good working relationships were observed between the staff on duty throughout the inspection.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements and maintaining good working relationships. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Preshela Baguio, Registered Nurse, 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.

7.1 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, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

7.2 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 11 November 2017	The registered person shall review procedures to ensure that all medicines are available for administration as prescribed. Ref: 6.4
	Response by registered person detailing the actions taken: Present monthly ordering systems have been checked and measures put in place to ensure that all medicines are available for administration ensuring that there are enough medicines in stock to cover each month supply
Action required to ensure compliance with The Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 11 November 2017	The registered person shall review the management of personal medication records to ensure that all records and any new entries are checked and signed by two competent members of staff to ensure accuracy in transcription. Ref: 6.4
	Response by registered person detailing the actions taken: Normal procedure is that all medication records are checked and signed by 2 competent members of staff and this practice will continue
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 11 November 2017	The registered person shall ensure that the storage temperature for medicines is monitored on a daily basis to ensure it does not exceed the maximum storage temperature of 25◦C. Ref: 6.4
	Response by registered person detailing the actions taken: The temperature in the treatment room will be checked and recorded daily to ensure that the maximum storage temperature of 25 oC is maintained at all times
Area for improvement 3 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 11 November 2017	The registered person shall review the cold storage of medicines to ensure that the refrigerator thermometer is reset daily when temperatures are recorded. Ref: 6.4
	Response by registered person detailing the actions taken: The refrigerator thermometer will continue to be checked daily and the thermometer will be reset when temperatures are recorded

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