Unannounced Medicines Management Inspection Report
30 January 2019

Glendun Nursing Home

Type of Service: Nursing Home
Address: 67 Knocknacarry Road, Cushendun, BT44 0NS
Tel No: 02821761222
Inspector: Judith Taylor

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 30 beds that provides care for patients living with a range of healthcare needs as detailed in Section 3.0. The nursing home is located on the same site as Glendun Residential Home.

3.0 Service details

Organisation/Registered Provider: Glendun Nursing Home Ltd **Responsible Individual:** Mr David Leo Morgan	**Registered Manager:** Mrs Katrina Mary O'Hara
Person in charge at the time of inspection: Mrs Katrina O'Hara	**Date manager registered:** 21 December 2018
Categories of care: Nursing Homes (NH) I – Old age not falling within any other category PH – Physical disability other than sensory impairment	**Number of registered places:** 30

4.0 Inspection summary

An unannounced inspection took place on 30 January 2019 from 10.40 to 15.40.

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 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 medicines training and competency assessment, the completion of most medicine records and care planning.

Areas for improvement were identified in relation to controlled drugs, the non-administration of medicines, the management of distressed reactions and records regarding swallowing difficulty.

The patient we met with spoke positively about the staff and the care provided. The patients were observed to be relaxed and comfortable in their environment.

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	4

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Katrina O'Hara, Registered Manager and Mr David Leo Morgan, Responsible Individual, 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 were required to be taken following the most recent inspection on 13 September 2018. Enforcement action did not result from the findings of this inspection.

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: none had been reported to RQIA since the last medicines management inspection

A poster was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

During the inspection we met with one patient, one registered nurse, one care assistant, the registered manager and the responsible individual.

We provided 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA and we asked the registered manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

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

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

We left ‘Have we missed you?’ cards in the home to inform patients and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

Areas for improvement 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 13 September 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was approved 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 5 February 2018

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered person shall review the governance arrangements for medicines management to ensure that these are robust.	**Met**
	Action taken as confirmed during the inspection: There was evidence that a range of audits were completed in relation to medicines management; and of the follow up action taken as necessary. The inspection findings indicate that whilst this auditing system was in place, areas for improvement were identified. We were advised of the recent appointment of the role of clinical lead nurse to support training and audit. Given this assurance, this area for improvement was assessed as met.	
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 person shall ensure that the date of opening is recorded for all medicines which are not supplied in the monitored dosage system (MDS).	**Met**
	Action taken as confirmed during the inspection: The date of opening was routinely recorded on medicines, including limited shelf life medicines. Compliance with this was included in the monthly audit process.	

Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered person shall make the necessary arrangements to review the care plans regarding swallowing difficulty to ensure that they reflect the current needs of the patients.	**Met**
	Action taken as confirmed during the inspection: We reviewed two patients' records regarding swallowing difficulty. A care plan was in place for both patients; however, information in one care plan was confusing and it required rewriting. The registered manager assured that this would be addressed with immediate effect. As written, this area for improvement has been assessed as met; however, due to the inspection findings in relation to other records regarding swallowing difficulty, a separate area for improvement has been identified. See Section 6.5.	
Area for improvement 3 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that a detailed record of all incoming medicines is maintained.	**Met**
	Action taken as confirmed during the inspection: An improvement in the completion of records for incoming medicines was evidenced. Staff were aware that details of all incoming medicines must be recorded.	

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. Staff competency assessments were completed following induction, at least annually and more frequently as required. The impact of training was monitored through team meetings, supervision and annual appraisal. Refresher training in medicines management was provided in the last year. A sample of records was provided.

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

Written confirmation of medicine regimes and any medicine changes were obtained. Personal medication records were updated by two trained staff. This is safe practice and was acknowledged.

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, report and follow up any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay.

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

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. Care plans were maintained. Each administration was checked and signed by two registered nurses. This safe practice was acknowledged.

The management of controlled drugs was reviewed. 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. In relation to Schedule 4 (Part 1) controlled drugs, two discrepancies were identified and these were highlighted to management to investigate. An area for improvement was identified. The need for a system to monitor Schedule 4 (Part 1) controlled drugs was also discussed.

With the exception of Schedule 4 (Part 1) controlled drugs, discontinued or expired medicines were safely disposed of. In relation to the disposal of all Schedule 4 (Part 1) controlled drugs, staff should ensure that these are denatured prior to disposal. This was also discussed in relation to the organisation's Standard Operating Procedures for controlled drugs. An area for improvement was identified.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised and patients' medicines were clearly segregated. There were robust systems to manage medicines which required cold storage and medicines with a limited shelf life once opened.

The management of lidocaine plasters was examined. Staff were reminded that each sachet must be kept sealed when not in use and it was suggested that staff ensure that a record of the removal of the patch is maintained.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and the safe storage of medicines.

Areas for improvement

Management should investigate the observations made regarding discrepancies in two Schedule 4 (Part 1) controlled drugs and forward a written report of the findings and action taken to RQIA.

The management of Schedule 4 (Part 1) controlled drugs should be reviewed in relation to monitoring and disposal.

	Regulations	Standards
Total number of areas for improvement	1	1

6.5 Is care effective?

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

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. Staff confirmed that patients were generally compliant with their medicine regimes. However, we noted that one patient regularly missed the daily dose of an eye preparation as the patient was asleep. This had not been reported to the prescriber and was discussed in relation to staff identifying ongoing non-administration and following up with management and the prescriber. An area for improvement was identified.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the separate administration records for transdermal patches and injectable medicines. There was evidence that time critical medicines had been administered at the correct time; and there were arrangements in place to alert staff of when doses of weekly or three monthly medicines were due.

We examined the management of medicines prescribed on a "when required" basis for distressed reactions. Medicine details were clearly recorded on the patient's personal medication record; however, not all patients had a care plan, and when administered, the reason for and the outcome of the administration were not routinely recorded. An area for improvement was identified. 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 sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff advised that most of the patients could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment was completed as part of the admission process.

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. Administration was recorded on separate charts which were replaced each day. Sometimes they included the consistency level; however, for one patient, the consistency level correlated with the speech and language report, on some but not all days. This was discussed with management for immediate review. See also Section 6.2. An area for improvement was identified.

With the exception of the non-compliance above, following discussion with the registered manager and staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to patients' healthcare needs. We were provided with examples in relation to the management of pain and diabetes.

Areas of good practice

There were some examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

Staff should ensure that the ongoing non-administration of one eye preparation is reported to the prescriber.

The management of distressed reactions should be reviewed to ensure that a care plan is in place and the reason for and outcome of any administration is recorded.

The management of swallowing difficulty should be monitored to ensure accurate information is recorded.

	Regulations	Standards
Total number of areas for improvement	0	3

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 not observed during the inspection. Following discussion with staff it was evident they were knowledgeable about the patients' medicines and how the patients preferred to take their medicines.

We noted the warm and welcoming atmosphere in the home. Throughout the inspection, it was found that there were good relationships between the staff, the patients and the patients' relatives/visitors. Staff were noted to be friendly and courteous and engaged with the patients; they treated the patients with dignity. It was clear from observation of staff, that they were familiar with the patients' likes and dislikes.

We met with one patient who spoke positively about the care provided, the food and the staff. 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.

During the inspection we observed patients listening to the musician who was visiting the home and also playing cards.

Of the questionnaires which were left for patients/patients' representatives, three were returned within the specified time frame (two weeks). The responses were recorded as very satisfied or satisfied with the care in the home. A comment was made in relation to a request for a specific activity and we contacted the home regarding this. One other comment was made:

"It is very good".

Any comments in questionnaires received after the return date will be shared with the registered manager as necessary.

Areas of good practice

Staff listened to patients and relatives and took account of their views.

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.

The new registered manager advised of her role and the support being provided by management. She provided details of the planned developments in relation to training and audit and the introduction of the role of clinical lead nurse.

The governance arrangements for medicines management were examined. We were advised of the auditing and monitoring systems to ensure sustained improvement, including the support from the community pharmacist. Management advised that medicines management was also reviewed within the regulation 29 monitoring visits. A sample of audit records was made available at the inspection.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. We were advised that there were arrangements in place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. Staff advised that they were made aware of any changes.

There were satisfactory systems for the management of medicine related incidents. Staff knew how to identify and report incidents, including referral to the safeguarding team as necessary. They provided details of the action taken to ensure that all staff were made aware of incidents and systems to prevent recurrence.

We were advised that there were effective communication systems to ensure that all staff were kept up to date.

Following discussion with the staff, it was evident that they 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.

The staff spoke positively about their work and advised there were good working relationships in the home and with other healthcare professionals. They stated they felt well supported in their work and stated they had no concerns.

No online questionnaires were completed by staff within the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. 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 Mrs Katrina O'Hara, Registered Manager and Mr David Leo Morgan, Responsible Individual, 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 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:** 1 March 2019	The registered person shall investigate the observations made in relation to two Schedule 4 (Part 1) controlled drugs and forward a written report of the findings and action taken. Ref: 6.4
	Response by registered person detailing the actions taken: Investigation undertaken and report of findings emailed to RQIA
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:** 1 March 2019	The registered person shall review the management of Schedule 4 (Part 1) controlled drugs in relation to monitoring and disposal. Ref: 6.4
	Response by registered person detailing the actions taken: All Registered staff informed at staff meeting 11/02/19 on the monitoring and disposal of all schedule 4 (part 1) controlled drugs
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 1 March 2019	The registered person shall ensure that staff report the ongoing non-administration of one medicine to the prescriber. Ref: 6.5
	Response by registered person detailing the actions taken: Staff informed of need to report the ongoing non administration of medication to GP at staff meeting 11/02/2019
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 1 March 2019	The registered person shall review the management of distressed reactions to ensure that a detailed care plan is maintained and records of the reason for and outcome of any administration are recorded. Ref: 6.5
	Response by registered person detailing the actions taken: Discussed with staff at the meeting 11/02/2019 to management of distressed recations and the recording of detailed care plan. Also need for recording the reason for administration and effectivness recorded in daily care notes.

Area for improvement 4 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 1 March 2019	The registered person shall review the record keeping in relation to swallowing difficulty and the administration of thickened fluids. Ref: 6.5
	Response by registered person detailing the actions taken: Record keeping in relation to swallowing difficulties review and updated in accordance with new guidlines. Supervision carried out with senior staff.

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

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