Unannounced Medicines Management Inspection Report
5 February 2018

Glendun Nursing Home

Type of Service: Nursing Home
Address: 67 Knocknacarry Road, Cushendun, BT44 0NS
Tel No: 028 2176 1222
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 on the same site as a residential care home.

3.0 Service details

Organisation/Registered Provider: Glendun Nursing Home Ltd **Responsible Individual:** Mr David Leo Morgan	**Registered Manager:** Mrs Clare Burke
Person in charge at the time of inspection: Mrs Clare Burke	**Date manager registered:** 4 June 2015
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 5 February 2018 from 10.30 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 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.

There were some examples of good practice in relation to training and competency assessment, care planning, safe storage of medicines and administration of most medicines.

Areas requiring improvement were identified in relation to the governance arrangements and record keeping.

Patients spoke positively about the management of their medicines and the care provided in the home. They were complimentary about the staff and management.

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 Mrs Clare Burke, Registered Manager, and Mr David Morgan, Registered Provider, 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 30 May 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 was displayed to inform visitors to the home that an inspection was being conducted.

During the inspection we met with two patients, one registered nurse, the registered manager and the registered provider.

Ten questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completion of an online questionnaire.

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

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 30 May 2017

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

6.2 Review of areas for improvement from the last medicines management inspection dated 22 November 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 18 **Stated:** First time	The registered provider should ensure that a care plan is maintained for patients prescribed medicines on a 'when required' basis for the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: A sample of patient care files was examined. A care plan regarding the management of distressed reactions was in place.	

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 medicines management was provided in the last year, following implementation of a new medicines system. 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 on an annual basis.
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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were satisfactory arrangements in place for the safe management of medicines during the patient's admission to the home and for the management of changes to prescribed medicines.

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. A number of Schedule 4 (Part 1) controlled drugs were held in stock. Some of these could not be audited as the date of opening was not recorded. It was advised that a monitoring system should be in place for Schedule 4 (Part 1) controlled drugs and further advice was given at the inspection. The registered manager was addressing this during the inspection.

Robust arrangements were observed for the management of high risk medicines e.g. insulin and anticoagulants. A care plan was maintained. It was suggested that a running stock balance should be maintained for anticoagulant injections; this was being implemented at the end of the inspection.

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

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. A few medicines which did not require cold storage or must not be stored in the medicines refrigerator were removed from the medicines refrigerator. Medicine storage areas were clean and organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. However, it was noted that one inhaler required replacement and this was addressed during the inspection. This was discussed in relation to the audit process, see Section 6.7.

The temperature of medicines storage areas was monitored and recorded each day and temperatures had been maintained within the accepted limit for medicines storage.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, supervision and appraisal and the management of medicines on admission and medicine changes.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

The majority of medicines were supplied in the monitored dosage system (MDS). Staff spoke positively about this new medicines system and how effective it was.

A variety of medicines which were not supplied in the MDS were selected for audit. Only a small number of these audits could be completed, as the date of opening was not recorded and/or a record of the receipt of the medicine was not in place. An area for improvement was identified. See also Section 6.7.

There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly and three monthly medicines were due.

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. A care plan was maintained.

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. Details of the reason for and outcome of the administration of these medicines were routinely recorded. This good practice was acknowledged. 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. Each administration was recorded. We reviewed two care plans. The prescribed consistency recorded in the care plan did not match the most recent speech and language assessment report. On review of the administration records, they indicated that the correct fluid consistency was being administered. An area for improvement was identified.

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. They provided examples of when a medicine formulation was changed to assist with the patient's compliance.

Some of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included double signatures on personal medication records and the use of separate administration records for transdermal patches. A few omissions were observed in the administration records and were discussed. It was concluded that the medicines had been administered, but had not been signed as given. It was agreed

that this would be raised with the staff. In relation to the records of the receipt of medicines, as stated above a number of incoming medicines had not been recorded. An area for improvement was identified.

Following discussion with the registered manager and staff and a review for care files, it was evident that when applicable, other healthcare professionals were contacted in response to patients' healthcare needs.

Areas of good practice

There were some examples of good practice found throughout the inspection in relation to care plans and medicine records. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

The date of opening should be recorded for each medicine.

The necessary arrangements should be made to ensure that patients' care plans are kept up to date at all times; the two care plans in relation to swallowing difficulty should be updated.

Detailed records for the receipt of all medicines should be maintained.

	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 was not observed at this inspection. Following discussion with staff it was evident that the patients were given plenty of time to swallow their medicines.

Throughout the inspection, it was found that there were good relationships between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity. It was clear from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes.

We noted the interactions between the staff and the patients' visitors and it was evident from these that there was a good rapport between them.

The patients we met with spoke positively about their care and the management of their medicines. They were complimentary regarding staff and management. Comments included:

"I am happy enough."
"The staff are very good, they look after me and get me anything I need."
"I enjoy the activities."
"This is a good home and I would recommend it."

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.
Of the questionnaires which were left in the home to facilitate feedback from patients and their representatives one was returned with the specified timeframe (two weeks). The responses indicated that they were very satisfied with all aspects of the care provided in the home.
One comment was also recorded:

"I am happy to know that my (relative) is being cared for at Glendun Nursing Home."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, listening to and valuing patients and taking account of the views of 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.

There was limited evidence to indicate that robust governance arrangements for medicines management were in place and were embedded into routine practice. Whilst it was acknowledged there were daily audits on controlled drugs and quarterly audits were completed, areas for improvement were identified. Following discussion with the registered persons, it was concluded that due to a number of contributory factors, management had been unable to maintain the usual frequency of auditing and monitoring of medicines management. This was discussed and an area for improvement was stated.

Written policies and procedures for the management of medicines were in place. These were not examined. Management advised that these were currently under review and development.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents and advised of how incidents were shared with them to inform learning and change of practice, if necessary. We were also advised that incidents and audit outcomes were also discussed at supervision sessions with staff. 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.

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

Staff confirmed that any medicines related concerns were raised with management. They advised that management were open and approachable and willing to listen. They also stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to management of medicine incidents, quality improvement and maintaining good working relationships.

Areas for improvement

The governance arrangements for medicines management should be reviewed to ensure that they are robust.

	Regulations	Standards
Total number of areas for improvement	1	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 Clare Burke, Registered Manager, and Mr David Morgan, Registered Provider, 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:** 7 March 2018	The registered person shall review the governance arrangements for medicines management to ensure that these are robust. Ref: 6.7
	Response by registered person detailing the actions taken: Governance arrangements for medicines management have been reviewed by the registered provider and the manager. Frequency of audits has been increased and review of medication management audits and will be undertaken by the registered provider and the nominated person during monthly visits.
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:** 7 March 2018	The registered person shall ensure that the date of opening is recorded for all medicines which are not supplied in the MDS. Ref: 6.5
	Response by registered person detailing the actions taken: Staff meeting was held 1/3/18. item on agenda was management of medications. it was reinforced with all staff that they must record date of opening for all medications outside the MDS. Compliance will be monitored by peers/management.
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 15 February 2018	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. Ref: 6.5
	Response by registered person detailing the actions taken: Care plans will be subject to increased audits to ensure they reflect current needs of patient
Area for improvement 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 7 March 2018	The registered person shall ensure that a detailed record of all incoming medicines is maintained. Ref: 6.5
	Response by registered person detailing the actions taken: Recording of incoming medicines was discusssed at staff meeting 3/3/18. Compliance will be monitored by peers/management.

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

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