Unannounced Medicines Management Inspection Report
11 October 2018

Dunanney Care Centre

Type of Service: Nursing Home
Address: 12 Glebe Road, Newtownabbey, BT36 6UW
Tel No: 028 9084 9349
Inspector: Helen Daly

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 with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Larchwood Care Homes (NI) Ltd **Responsible Individual:** Mr Christopher Walsh	**Registered Manager:** Ms Christina Dobruszek-McGuigan
Person in charge at the time of inspection: Ms Maria Bordea, Registered Nurse	**Date manager registered:** 29 May 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:** 40 This number includes a maximum of three named residents receiving residential care in category RC-I and three named residents receiving residential care in category RC-MP (E).

4.0 Inspection summary

An unannounced inspection took place on 11 October 2018 from 10.30 to 14.00.

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 administration, medicine records, medicine storage and the management of controlled drugs.

Areas for improvement were identified in relation to the adding medicines to food to assist swallowing and the management of distressed reactions.

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	1

Details of the Quality Improvement Plan (QIP) were discussed with Ms Maria Bordea, Registered Nurse, and Ms Christina Dobruszek-McGuigan, Registered Manager, by telephone on 12 October 2018, 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 14 August 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 home was reviewed. This included the following:

- recent inspection reports
- 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 the inspector met with one patient, three care assistants and two registered nurses.

We provided the person in charge with 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. We left 'Have we missed you?' cards in the home to inform patients/their representatives, how to contact RQIA to tell us of their experience of the quality of care provided. Flyers providing details of how to raise concerns were also left in the home.

We asked the person in charge 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 requested and received
- personal medication records
- medicine administration records
- care plans
- medicines storage temperatures
- controlled drug record book

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 14 August 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. The 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 23 October 2017

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 ensure that medicines prescribed for the treatment of eye conditions are administered in accordance with the prescriber's instructions.	**Met**
	Action taken as confirmed during the inspection: We reviewed the management of eye preparations for several patients and there was evidence that they were being administered as prescribed. One recent anomaly was highlighted to the registered manager for follow up.	

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 registered nurses who have been trained and deemed competent to do so. Update training was provided by the community pharmacist. Competency assessments were completed following induction and if a need was identified through the auditing system or following medication related incidents. Care assistants had received training and been deemed competent to administer thickening agents.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training had been provided in March and September 2018.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and to manage medication changes. Personal medication records and hand-written entries on the medication administration records were verified and signed by two registered nurses. This safe practice was acknowledged. Registered nurses were reminded that the date must be accurately recorded on hand-written medication administration records.

There were systems in place to ensure that patients had a continuous supply of their prescribed medicines. There was evidence that antibiotics and newly prescribed medicines had been received into the home without delay.

Medicines were crushed and added to food to assist administration. A care plan detailing how the medicines were administered was not in place and a pharmacist had not been consulted to confirm the suitability of adding the particular medicines to food. An area for improvement was identified.

The management of medicines to be administered via the enteral route was examined. A record of the daily regimen including the required water flushes was observed. Daily fluid intake charts were in place. Registered nurses were reminded that the daily fluid intake charts should be totalled each day to provide evidence that the recommended daily fluid intake is being achieved.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. Checks were performed on controlled drugs which require safe custody at the end of each shift.

Satisfactory arrangements were in place for the safe disposal of discontinued or expired medicines.

The majority of medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Medicine refrigerators and oxygen equipment were checked at regular intervals. However, the temperature of the refrigerator on the first floor had been above 8^{o}C in recent days. This was discussed with the registered manager who provided assurances that all registered nurses would receive supervision on resetting the thermometer.

Areas of good practice

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

Areas for improvement

The registered person shall review the management of medicines which are added to food to assist swallowing. Detailed care plans should be in place. A pharmacist should be consulted to confirm the suitability of adding the medicines to food.

	Regulations	Standards
Total number of areas for improvement	1	0

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 been administered in accordance with the prescriber's instructions. 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 72 hourly and weekly 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. Registered nurses advised that they knew how to recognise signs, symptoms and triggers which may cause a change in each patient's behaviour and were aware that this change may be associated with pain. One care plan was not in place, the registered manager advised that it had been written immediately following the inspection. The reason for and the outcome of administration was not being recorded on all occasions. An area for improvement was identified.

Satisfactory systems were in place for the management of pain and swallowing difficulty.

Registered nurses advised 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. A small number of obsolete personal medication records needed to be cancelled and archived and this was discussed.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicines which were not supplied in the blister pack system.

Following discussion with the registered nurses, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in patient care.

Areas of good practice

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

Areas for improvement

The reason for and outcome of administration of “when required” medicines for the management of distressed reactions should be recorded.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

We did not observe the administration of medicines during the inspection. Registered nurses were aware of where and how each patient liked to take 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 each patients’ likes and dislikes. Patients were observed to be relaxed and comfortable.

We spoke with one patient who was complimentary regarding the care provided and staff in the home.

As part of the inspection process, we issued 10 questionnaires to patients and their representatives. None were returned within the specified time frame.

Any comments from patients and their representatives in questionnaires received after the return date (two weeks) will be shared with the registered manager for information and action as required.

Areas of good practice

Staff were observed to listen to patients and to respond to requests without delay.

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.

We discussed 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. Arrangements were in place to implement the collection of equality data within Dunanney Care Centre.

Written policies and procedures for the management of medicines were in place. They were not reviewed at the inspection.

There were robust arrangements in place for the management of medicine related incidents. Registered nurses advised that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff advised that they were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were examined. Management advised of the auditing processes completed by both staff and management. Areas identified for improvement were detailed in an action plan which was shared with staff to address and there were systems in place to monitor improvement.

Following discussion with the registered nurses and care assistants, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They advised that any concerns in relation to medicines management were raised with the registered manager.

The staff we met with spoke positively about their work and advised there were good working relationships in the home with staff and the registered manager. They stated they felt well supported in their work.

We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date. In addition to verbal handovers, handover sheets were in place.

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 Ms Maria Bordea, Registered Nurse, and with Ms Christina Dobruszek-McGuigan, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

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

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

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:** 11 November 2018	The registered person shall review and revise the management of medicines which are added to food to assist swallowing. Ref: 6.4
	Response by registered person detailing the actions taken: Pharmacy contacted and permission sought for medicaiton to be admininstered in this way. Appropraiate care plans now in place.
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 18 **Stated:** First time **To be completed by:** 11 November 2018	The registered person shall ensure that the reason for and outcome of administration of “when required” medicines for the management of distressed reactions is recorded. Ref: 6.5
	Response by registered person detailing the actions taken: Supervision carried out with all nursing staff on the 5th November highlighting the importance of the above. The home manager wil review this monthly when auditing.

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

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