Unannounced Medicines Management Inspection Report
18 December 2017

The Glebe Care Centre

Type of Service: Nursing Home
Address: 12 Glebe Road, Carnmoney, Newtownabbey, BT36 6UW
Tel No: 028 9084 8212
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 38 beds that provides care for patients and residents living with a range of health 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:** Mrs Geraldine Boyce
Person in charge at the time of inspection: Mrs Geraldine Boyce	**Date manager registered:** 28 June 2012
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 (RC) 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:** 38 This includes a maximum of six persons accommodated for residential care.

4.0 Inspection summary

An unannounced inspection took place on 18 December 2017 from 10.20 to 15.45.

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 term ‘patients’ is used to describe those living in The Glebe Care Centre which at this time 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.

Overall, there was evidence of good practice was found in relation to the completion of most medicine records, medicines storage and the management of controlled drugs.

Areas requiring improvement were identified in relation to the administration of medicines, care planning and the updating of medicine records.

Patients spoke positively about the management of their medicines and the care provided by the staff.

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	0	*3

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Geraldine Boyce, Registered Manager, 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 6 November 2017. 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 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 senior care staff, one registered nurse, the activities co-ordinator and the registered manager.

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

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 completing an online questionnaire.

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 6 November 2017

The most recent inspection of the home was an unannounced care inspection. The report and QIP had been issued at the time of writing this report. The completed QIP will be reviewed by the care inspector and validated at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 7 April 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 38 **Stated:** Second time	The registered manager should ensure that two nurses are involved in the disposal of all medicines and both nurses sign the record of disposal.	**Met**
	Action taken as confirmed during the inspection: Examination of the disposal of medicines record book indicated that two nurses were routinely involved in the disposal of medicines.	

Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered manager should review the disposal of medicines to ensure that all discontinued or expired controlled drugs in Schedule 4 (Part 1) are denatured prior to disposal.	**Met**
	Action taken as confirmed during the inspection: Two staff had recorded the disposal of Schedule 4 controlled drugs. However, the record did not indicate if these had been denatured. The registered manager confirmed that they had been denatured prior to disposal. It was agreed that staff would be reminded to record this information. Given these assurances the area for improvement was assessed as met.	
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time	The registered manager should closely monitor the administration of medicines to ensure these are administered as prescribed.	**Partially met**
	Action taken as confirmed during the inspection: This area for improvement was made in relation to inhaled medicines and external preparations. Further discrepancies in the administration of these medicines and also eye preparations were noted at the inspection. This area for improvement has been stated for a second time.	
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time	Where medicines are administered to manage distressed reactions, the reason for and the outcome of the administration should be recorded.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the reason for and outcome of administration of these medicines were recorded in the patients' daily progress notes.	

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

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 procedures in place to ensure the safe management of medicines during a patient's admission to the home.

The management of medicine changes was reviewed. Two staff were routinely involved in updating the personal medication records. This is safe practice. However, this was not observed for transcribing information on medication administration records and warfarin administration records. An area for improvement was identified.

The management of high risk medicines such as insulin and anticoagulants were examined. Largely satisfactory arrangements were in place. One care plan regarding insulin required further information (see also Section 6.5). Written confirmation of one anticoagulant dosage regime was not in place; staff advised that this was usually telephoned to the staff and followed up in writing. It was agreed that the prescriber would be contacted to obtain this.

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 performed on some other controlled drugs which is good practice.

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. 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.

Areas of good practice

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

Areas for improvement

The recording of new medicines information should be reviewed to ensure that any transcribing involves two staff and both staff sign the entry.

	Regulations	Standards
Total number of areas for improvement	0	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. However, discrepancies were noted in inhaled medicines, and records of administration were incomplete in relation to eye preparations and external preparations. These were discussed with staff and the registered manager. This issue had been raised at the last medicines management inspection and the area for improvement has been stated for a second time.

There were satisfactory arrangements in place to alert staff of when time critical medicines must be administered, such as early morning medicines and also medicines which were prescribed at weekly and three monthly intervals.

The management of distressed reactions was reviewed. When a patient was prescribed a medicine for administration on a "when required" basis the dosage instructions were recorded on the personal medication record. Staff confirmed that they 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 the administration was 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 advised that all of the patients could tell staff if they were experiencing pain and confirmed that staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Whilst it was acknowledged that pain management was referenced in a care plan, several required further detail. An area for improvement was identified.

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 and care plans and speech and language assessment reports were in place.

The management of diabetes was reviewed. One personal medication record required updating in relation to the insulin dosage regime and it was agreed that this would be addressed immediately after the inspection. Records of administration indicated the correct dosage was being administered. However, a detailed care plan was not maintained.

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 confirmed that patients were generally compliant with their medicine regimes.

Overall, medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the maintenance of separate administration records for transdermal patches and high risk medicines.

Practices for the management of medicines were audited regularly by the staff throughout the month and monthly by the registered manager. This included a record of the stock balance of medicines carried forward to the next medicine cycle. This good practice was acknowledged. A quarterly audit was also completed by the community pharmacist.

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.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the administration of most medicines, the standard of record keeping. Staff were knowledgeable regarding the patients' medicines.

Areas for improvement

One area for improvement has been stated for a second time in relation to the administration of medicines.

Patient care plans regarding pain management and diabetes should be further developed.

	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 observed the administration of a small number of medicines. Staff spoke to patients in a kind and caring manner and the patients were given 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.

The patients we met with spoke positively about their care and the management of their medicines. Comments included:
"I am feeling good."
"The staff do help me."
"I like it here."

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, none were returned with the specified timescale (two weeks). One staff member completed the online questionnaire. They indicated that they were satisfied with all aspects of the care provided in the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff listening to and valuing patients and taking account of the their views.

Areas for improvement

No areas for improvement were identified.

	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. Some of these had been updated in the last year. Staff advised that they were familiar with them and were kept up to date of any changes.

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 as part of the quality meetings which were held every month. 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.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. There was evidence that when an area for improvement was identified, this was shared with staff and an action plan was also developed.

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 concerns in relation to medicines management 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.

Areas of good practice

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

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 Geraldine Boyce, 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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 28 **Stated:** Second time **To be completed by:** 19 January 2018	The registered manager should closely monitor the administration of medicines to ensure these are administered as prescribed. Ref: 6.2 & 6.5
	Response by registered person detailing the actions taken: An audit is carrie dout monthly on all medications in the Home. A yearly medication training schedule is in place for all staff who administer medication.
Area for improvement 2 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 19 January 2018	The registered person shall ensure that two staff are involved in the transcribing of medicines information on medicine records; both staff should initial the entry. Ref: 6.4
	Response by registered person detailing the actions taken: All trained staff have received a supervision regarding this. They are now all aware 2 staff must initial all entries on MARS sheets
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 19 January 2018	The registered person shall review patients' care plans regarding medicines management to ensure that these are further developed and include the necessary detail. Ref: 6.5
	Response by registered person detailing the actions taken: Care Plans have been reviewed. Where necessary these have been developed to include appropriate use of PRN analgesia and topical medication.

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

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