Unannounced Medicines Management Inspection Report
5 February 2018

Dunlarg Care Home

Type of Service: Nursing Home
Address: 224 Keady Road, Armagh, BT60 3EW
Tel No: 028 3753 0858
Inspector: Catherine Glover and Kieran McCormick

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 58 beds that provides care for patients with a range of care needs as described in Section 3.0.

On 12 February 2018 Four Seasons (Bamford) Ltd registered the eight residential beds as a separate residential care home on the same site.

3.0 Service details

Organisation/Registered Provider: Four Seasons (Bamford) Ltd **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** Mrs Patricia Graham
Person in charge at the time of inspection: Mrs Patricia Graham	**Date manager registered:** 30 May 2012
Categories of care: Nursing Homes LD – Learning disability PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years I – Old age not falling within any other category DE – Dementia Residential Homes I – Old age not falling within any other category MP(E) - Mental disorder excluding learning disability or dementia – over 65 years	**Number of registered places:** 58 comprising 50 nursing and 8 residential A maximum of 10 patients in categories NH-PH/NH-PH(E) and a maximum of 8 patients in category NH-LD.

4.0 Inspection summary

An unannounced inspection took place on 5 February 2018 from 10.40 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 Dunlarg Care Home 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 the management of pain and controlled drugs.

Areas requiring improvement were identified in relation to the maintenance of patient records, the audit and governance arrangements, the admissions process and the management of thickened fluids.

As a result of this inspection, RQIA was concerned that the issues evidenced during the inspection had the potential to affect the health and well-being of patients. A decision was taken to hold a serious concerns meeting to discuss the findings. The meeting was held at RQIA Belfast office on 8 February 2018 (see Section 4.1).

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	*3	*5

*The total number of areas for improvement includes two which have been stated for a third and final time (one in relation to the regulations and one in relation to the standards) and two which have been stated for a second time in relation to the standards.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Patricia Graham, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action resulted from the findings of this inspection. The responsible individual and registered manager were invited to attend a serious concerns meeting in RQIA on 8 February 2018 to discuss the inspection findings and their plans to address the issues identified at the inspection. During the meeting, the representative of the responsible person, Mrs Ruth Burrows (Resident Experience Regional Manager), provided a comprehensive action plan to address the concerns raised during the inspection. Assurance was given that the concerns were being taken very seriously by Four Seasons Health Care. Following the meeting RQIA decided to allow a period of time to demonstrate that the improvements had been made and advised that a further inspection would be completed to ensure that the concerns had been effectively addressed.

RQIA informed the representatives of Four Season Health Care that further enforcement action may be considered if the issues were not addressed and sustained. RQIA will continue to monitor progress during subsequent inspections.

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

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 26 September 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

Prior to the inspection, it was ascertained that no incidents involving medicines had been 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, the registered manager and three registered nurses.

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.

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

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 26 September 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 23 January 2017

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 13 (4)

Stated: Second time</td><td>The registered person must ensure that the personal medication record sheets are accurately maintained.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The personal medication records reviewed had not been fully and accurately maintained. The details of some prescribed medicines had not been included, medicines that had been discontinued had not been cancelled and dosage changes had not been recorded.

Following discussion at the serious concerns meeting this area for improvement has been stated for a third and final time.</td></tr>
</table>

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 37 **Stated:** Second time	The registered person should ensure that the recording system for all patients who are prescribed 'when required' medicines for the treatment of distressed reactions is reviewed.	**Not met**
	Action taken as confirmed during the inspection: Care plans for the management of distressed reactions were not completed and there were no records for the reason and outcome of administration of these medicines. Following discussion at the serious concerns meeting this area for improvement has been stated for a third and final time.	
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time	The registered provider should ensure that the disposal of medicines record is signed by two designated staff members.	**Not met**
	Action taken as confirmed during the inspection: This record had not always been signed by two staff members. This area for improvement has been stated for second time.	
Area for improvement 3 **Ref**: Standard 28 **Stated:** First time	The registered provider should ensure that a comprehensive medicines management auditing system is in place.	**Not met**
	Action taken as confirmed during the inspection: The outcome of this inspection indicated that a robust auditing system was not in place. This area for improvement has been stated for second time.	

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.

The registered manager confirmed that medicines were managed by staff who have been trained and deemed competent to do so. Samples of training and competency assessments were provided for inspection. An induction process was in place for registered nurses. As a result of this inspection, Four Seasons management advised RQIA at the serious concerns meeting, that the competency of all registered nurses would be reassessed.

Generally satisfactory systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. One medicine was observed to be out of stock for two days prior to the inspection, however it was being followed up by the registered nurse on duty. 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.

The arrangements in place to manage changes to prescribed medicines must be reviewed and revised. The personal medication records reviewed had not been fully and accurately maintained. The details of some prescribed medicines had not been included, medicines that had been discontinued had not been cancelled and dosage changes had not been recorded. The area for improvement stated previously in relation to personal medication records has been stated for a third and final time (see Section 6.2).

A significant number of patients had been prescribed an antiviral medicine at the time of this inspection. Discrepancies were noted in the management of this medicine for several patients. A generic medication record had been generated and signed by two nurses and then photocopied for use by all patients prescribed this medicine. This additional record was not cross-referenced on the main personal medication records and was inaccurate for some patients. This was discussed at the serious concerns meeting and assurance was given that this was being fully investigated and rectified.

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

The procedures in place to ensure the safe management of medicines during a patient's admission to the home must be reviewed. It was noted that the personal medication record had not been fully and accurately completed for one recently admitted patient and that the patient's medicines had not been administered as prescribed. An area for improvement was identified.

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. The running stock balance of warfarin tablets for one patient was noted to be incorrect although the correct dosage had been administered. This was discussed with the registered manager 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. It was noted that the disposal record was not signed on some occasions and one nurse had signed on other occasions. This record should be signed by two designated staff members. The area for improvement identified previously has been stated for a second time (see Section 6.2).

Medicines were stored safely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. It was noted that the locks on some of the overstock cupboards were broken. The registered manager advised that a new treatment room was being built but that these locks would be repaired.

There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The medicine refrigerator and oxygen equipment were checked at regular intervals.

Areas of good practice

There were examples of good practice in relation to controlled drugs and the prompt acquisition of antibiotics.

Areas for improvement

One new area for improvement was identified in relation to the admission process with respect to medicines management.

	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 majority of medicines were supplied in a monitored dosage system. A sample of medicines that were not contained in the monitored dosage system was audited during the inspection. There were significant discrepancies in the audits of inhaled medicines and medicines for the treatment of diabetes which indicated that they had not been administered in accordance with the prescriber's instructions. This had not been identified during the auditing process within the home and no medicine incidents had been reported since the previous medicines management inspection. This indicated that the auditing process within the home was not robust. An area for improvement that was identified previously has been stated for a second time (see Section 6.2).

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, monthly or three monthly medicines were due.

The management of new and acute prescribed medicines was examined. Care records did not evidence the deterioration in the health and the reason for the prescribing of antibiotics and dose changes of prescribed medicines for one patient. The care records for a second patient documented that the patient was unwell and unsettled. This patient was prescribed analgesia to be administered up to four times per day. The administration records showed that this was administered once daily at night for several days. The care records did not accurately reflect the well-being of the patients. An area for improvement was identified.

The management medicines for administration on a "when required" basis of distressed reactions was examined. On one occasion one of the prescribed medicines was not recorded on the personal medication record. A care plan had not been completed and implemented for those patients prescribed these medicines. The reason for and the outcome of administration were not recorded. The area for improvement identified previously has been stated for a second time (see Section 6.2).

The sample of records examined indicated that, with the exception mentioned above, 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 tool was used as needed. A care plan was maintained although the monthly review had not been completed. This was discussed with the registered manager for action at the end of the inspection.

The management of swallowing difficulty was examined. Although the thickening agent had been included on the personal medication record, the details of the fluid consistency had not been documented. There were discrepancies in the consistency of thickened fluids that had been recorded on the care plans compared with the information on the speech and language assessment reports. An area for improvement was identified.

Areas of good practice

There were examples of good practice in relation to the management of pain.

Areas for improvement

The consistency of thickened fluids should be accurately recorded on all relevant records.

The care records must accurately reflect the health and well-being of patients and any decisions that have been taken regarding their care.

	Regulations	Standards
Total number of areas for improvement	1	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.

The administration of medicines to patients was not observed during this inspection; however, staff were knowledgeable regarding patients' medicines, and their needs and wishes.

Throughout the inspection, good relationships were observed between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity.

Patients spoken to at the inspection advised that they liked the home and 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.

None of the questionnaires left in the home to facilitate feedback from patients and relatives were returned prior to the issue of this report.

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.

Written policies and procedures for the management of medicines were in place. They were not examined during this inspection.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. This was inconsistent with the findings of this inspection. Audits were completed regularly in the home but were not effective in identifying shortfalls in the management of medicines. As stated in Section 6.5 and 6.2, the audit process must be reviewed to ensure it is robust. The area for improvement in relation to this has been restated for a second time.

Following discussion with the registered manager and registered nurses, it was evident that staff were not clear on their roles and responsibilities in relation to medicines management. There was lack of ownership by the registered nurses in completing care plans, personal

medication records and progress notes. This was discussed at the serious concerns meeting. The registered person should ensure that all registered nurses are reminded of and adhere to the NMC Code of Professional Conduct.

None of the areas for improvement made at the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement sustained, that the QIP should be regularly reviewed as part of the quality improvement process.

No members of staff shared their views by completing the online questionnaire prior to the issue of this report.

Areas of good practice

There are established Four Seasons Health Care policies and procedures for staff reference.

Areas for improvement

The QIP should be regularly reviewed as part of the quality improvement process.

	Regulations	Standards
Total number of areas for improvement	0	1

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 Patricia Graham, 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:** Third and final time **To be completed by:** 5 March 2018	The registered person must ensure that the personal medication record sheets are accurately maintained. Ref: 6.2
	Response by registered person detailing the actions taken: The Registered Manager requested a full and current up to date medication list from all GPs which were used to rewrite the medication kardex. A system has been devised to ensure that each residents prescription sheet are audited each month.
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 5 March 2018	The registered person shall ensure the admission process with respect to medicines management is robust. Ref: 6.4
	Response by registered person detailing the actions taken: When a resident is admitted the Registered manager or delegated Registered Nurse will complete a medication audit ensuring that the GP list or hospital pharmacy discharge list is used to formulate the prescription kardex, Two nurses to check and sign kardex. Medication audits to be completed via QoI.
Area for improvement 3 **Ref:** Regulation 13(1) **Stated:** First time **To be completed by:** 5 March 2018	The registered person shall ensure the care records accurately reflect the health and well-being of patients and any decisions that have been taken regarding their care. Ref: 6.5
	Response by registered person detailing the actions taken: The Registered manager and named nurses have completed a full review of residents care records and updated any that were required to accuratelly reflect their health and well being.

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:** Third time **To be completed by:** 5 March 2018	The registered person should ensure that the recording system for all patients who are prescribed 'when required' medicines for the treatment of distressed reactions is reviewed. Ref: 6.2
	Response by registered person detailing the actions taken: The Registered Manager and Nursing staff have completed a full review of residents who are prescribed as and when required medications for distressed reactions. Registered staff are fully aware that they are required to record the effectivness on Mar and progress sheet.
Area for improvement 2 **Ref**: Standard 29 **Stated:** Second time **To be completed by:** 5 March 2018	The registered provider should ensure that the disposal of medicines record is signed by two designated staff members. Ref: 6.2
	Response by registered person detailing the actions taken: The Registered Manager has completed supervision with Registered Nurses and discussed the importance that the disposal of medicines record requires to be signed by two designated staff. The registered manager will monitor this through the home managers monthly medication audit.
Area for improvement 3 **Ref**: Standard 28 **Stated:** Second time **To be completed by:** 5 March 2018	The registered provider should ensure that a comprehensive medicines management auditing system is in place. Ref: 6.2
	Response by registered person detailing the actions taken: The registered manager has devised a system that each resident medication will be audited throughout the month. Audits utukised will include the daily and weekly medication audit on Qol. Also the home managers monthly medication audit is in place. Registered manager will be supported with auditing by the Support Manager, Resident experience team and Regional manager.
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 5 March 2018	The registered person shall ensure that the consistency of thickened fluids is accurately recorded on all relevant records. Ref: 6.5
	Response by registered person detailing the actions taken: The Registered Manager with Nursing staff completed a full review of residents care records and those currently requring fluids thickened have the consistency accurately recorded. Registered Manager will continue to monitor this through the auditing process.

Area for improvement 5 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 5 March 2018	The registered person shall ensure that the QIP is regularly reviewed as part of the quality improvement process. Ref: 6.7
	Response by registered person detailing the actions taken: The Registered Manager has commenced an evidence file. The QIP findings were discussed at the Registered Nurse meeting and will remain on the agenda for forthcoming meetings and or supervisions.

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

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