Unannounced Medicines Management Inspection Report
23 January 2017

Dunlarg Care Home

Type of Service: Nursing Home
Address: 224 Keady Road, Armagh, BT60 3EW
Tel no: 02837530858
Inspectors: Paul Nixon and Frances Gault

1.0 Summary

An unannounced inspection of Dunlarg Care Home took place on 23 January 2017 from 10:00 to 14:10.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence that the management of medicines mostly supported the delivery of safe care and positive outcomes for patients. However, improvements were needed in the management of changes to prescribed medicines. Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards.

Is care effective?

Improvements were required if the management of medicines is to fully support the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Some documentation in relation to the personal medication records and the management of distressed reactions still requires attention. The requirement and recommendation made at the previous inspection were restated. In addition, shortfalls were also observed in the disposal records and the current medicines audit system; two recommendations were made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for patients. Patients consulted with confirmed that they were administered their medicines appropriately. There were no areas of improvement identified.

Is the service well led?

The current auditing system was not comprehensive. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity.

This inspection was underpinned by 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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 standards until compliance is achieved. Please also refer to sections 4.2 and 5.0 of this report.

For the purposes of this report, the term 'patients' will be used to described those living in Dunlarg Care Home which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Registered Nurse Marian Hughes, Nurse in Charge and other registered nurses on duty and also with Ms Patricia Graham, Registered Manager, via telephone on 23 January 2017, 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.

1.2 Actions/enforcement taken following the most recent estates inspection

Other than those actions detailed in the QIP, there were no further actions required to be taken following the most recent inspection on 21 July 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons (Bamford) Ltd Dr Maureen Claire Royston	**Registered manager:** Ms Patricia Graham
Person in charge of the home at the time of inspection: Registered Nurse Marian Hughes	**Date manager registered:** 30 May 2012
Categories of care: RC-I, RC-MP(E), NH-LD, NH-PH, NH-PH(E), NH-DE, NH-I	**Number of registered places:** 58 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.

3.0 Methods/processes

Prior to inspection the following records were analysed:

- 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.

We met with ten patients, three registered nurses and two care assistants.

Twenty-five questionnaires were issued to patients, patients' representatives and staff with a request that they were returned within one week from the date of this inspection.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

The following records were 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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 21 July 2016

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

4.2 Review of requirements and recommendations from the last medicines management inspection 16 September 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time	The registered person must ensure that the incident where Clexane injection had not been administered to a patient for four days is investigated and a written response submitted to RQIA.	**Met**
	Action taken as confirmed during the inspection: This incident was investigated by management and a written response was received by RQIA on 20 October 2014.	
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered person must ensure that the personal medication record sheets are accurately maintained.	**Not Met**
	Action taken as confirmed during the inspection: Some personal medication record sheets were observed to be inaccurate, with not all prescribed medicines recorded and/or not all discontinued medicine entries cancelled. **This requirement is restated.**	
Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered person must ensure that the disposals of all medicines are recorded.	**Met**
	Action taken as confirmed during the inspection: The requirement, as stated, had been addressed.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	There should be evidence of professional advice for any unlicensed use of medicines.	**Met**
	Action taken as confirmed during the inspection: Although there was no current unlicensed use of medicines, the registered nurses confirmed that the prescriber would be requested to provide written confirmation for this arrangement.	
Recommendation 2 **Ref**: Standard 37 **Stated:** First 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: The records reviewed of two out of three patients who were prescribed 'when required' medicines for the treatment of distressed reactions did not include a care plan. **This recommendation is restated.**	
Recommendation 3 **Ref**: Standard 38 **Stated:** First time	Handwritten entries on the medication administration record sheets should be signed by two designated staff members.	**Met**
	Action taken as confirmed during the inspection: The majority of handwritten entries on the medication administration record sheets had been signed by two registered nurses.	

4.3 Is care safe?

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. The most recent training was in relation to eating and swallowing difficulties in palliative and end of life care.

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.

Improvements were needed in the management of changes to prescribed medicines; several personal medication record sheets had not been updated following medication changes – a requirement was restated relating to the accurate maintenance of personal medication record sheets (see sections 4.2 and 4.4). Personal medication records and handwritten entries on medicine administration records were generally updated by two registered nurses; this safe practice was acknowledged.

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.

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. 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 for improvement

Personal medication record sheets must be accurately maintained; a requirement was restated in section 4.4.

Number of requirements	0	**Number of recommendations**	0

4.4 Is care effective?

The sample of medicines examined had mostly been administered in accordance with the prescriber's instructions. Several audits that produced unsatisfactory outcomes were drawn to the attention of the registered manager, who gave an assurance that the administrations of these medicines would be closely monitored.

There was evidence that time critical medicines had been administered at the correct time. The need to record the next date of administration of a three monthly injection on the medicine administration record was discussed and an assurance was given that this matter would be addressed without delay.

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. Medicines were seldom used in this manner. 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. However, as stated above in section 4.2, the records reviewed of two out of three patients who were prescribed 'when required' medicines for the treatment of distressed reactions did not include a care plan. A recommendation in relation to this was restated.

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

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.

As stated in sections 4.2 and 4.3, some personal medication record sheets were not accurate; a requirement in relation to this was restated. With the exception of entries for controlled drugs, the disposal of medicines record was not signed by two registered nurses; a recommendation was made. Other medicine records were generally well maintained and facilitated the audit process. Areas of good practice were acknowledged; they included additional records for insulin, transdermal patches and warfarin.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicines not dispensed in monitored dosage system blister packs. However, the fact that one requirement and one recommendation were restated and also that several medicine audits produced unsatisfactory outcomes indicated the current auditing system was not comprehensive; a recommendation was made.

Following discussion with the staff, it was evident that, when applicable, other healthcare professionals are contacted in response to the health needs of patients.

Areas for improvement

The recording system for all patients who are prescribed 'when required' medicines for the treatment of distressed reactions should be reviewed; a recommendation was restated.

Personal medication record sheets must be accurately maintained; a requirement was restated.

The disposal of medicines record should be signed by two designated staff members; a recommendation was made.

A comprehensive medicines management auditing system should be in place; a recommendation was made.

Number of requirements	1	**Number of recommendations**	3

4.5 Is care compassionate?

The administration of medicines to patients was completed in a caring manner, patients were given time to take their medicines and medicines were administered as discreetly as possible. However, one medicine trolley was observed to be left unattended; this observation was drawn to the attention of the registered nurses on duty. One patient was observed to have been left their medication to take unattended; the need for a risk assessment to be in place for this arrangement was discussed and an assurance was given by the registered nurse that the matter would be addressed.

Patients spoken to advised that they were very satisfied with the care experienced. 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.

As part of the inspection process, we issued questionnaires to patients, patients' representatives and staff. One patient's representative completed and returned a questionnaire within the specified timeframe. Comments received were very positive; the responses were recorded as 'very satisfied' with the management of medicines in the home.

Areas for improvement

A comprehensive medicines management auditing system must be in place; see section 4.4.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents.

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

As stated in section 4.4, the fact that one requirement and one recommendation were restated and also that several medicine audits produced unsatisfactory outcomes indicated the current auditing system was not comprehensive. To ensure that any requirements and recommendations are fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Staff confirmed that any concerns in relation to medicines management were raised with management.

Areas for improvement

A comprehensive medicines management auditing system should be in place; a recommendation was made in section 4.4.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Registered Nurse Marian Hughes and also with Ms Patricia Graham, Registered Manager, via telephone, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time **To be completed by:** 22 February 2017	The registered person must ensure that the personal medication record sheets are accurately maintained.
	Response by registered provider detailing the actions taken: All medication kardex's have been re writen. The Registered Nurses will monitor this through the daily medication TRaCA audits. The Registered Manager will oversee this as part of the monthly medication audit.
Recommendations	
Recommendation 1 **Ref**: Standard 37 **Stated:** Second time **To be completed by:** 22 February 2017	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.
	Response by registered provider detailing the actions taken: This has now been reviewed by the Registered Manager together with the Registered Nurses. The recording for patients who have prescribed `when required` medications have now care plans completed. The Registered Manager will monitor this as part of monthly medication audit.
Recommendation 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 22February 2017	The registered provider should ensure that the disposal of medicines record is signed by two designated staff members.
	Response by registered provider detailing the actions taken: The Registered Manager has discussed the requirement for two signatures on the disposal of medications with the Registered Nurses under clinical supervision. Compliance will be monitored via the monthly medication audit.
Recommendation 3 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 22February 2017	The registered provider should ensure that a comprehensive medicines management auditing system is in place.
	Response by registered provider detailing the actions taken: The Registered Manager has reviewed the current auditing system. Any outcomes of daily, weekly and monthly medication audits that require to be addressed will be discussed under clinical supervision with the Registered Nurses.

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews