Unannounced Medicines Management Inspection Report
13 July 2017

Glenview

Type of Service: Nursing Home
Address: 9 Cabragh Road, Dungannon, BT70 3AH
Tel No: 028 8776 7132
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 servicefrom 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 homewhich provides care for 45 patients with a range of care needs.

3.0 Service details

Organisation/Registered Provider: Glenview **Responsible Individual(s):** Mr Mervyn John Gregg Mrs Jennifer Elizabeth Gregg	**Registered Manager:** Mrs Veronica McElmurry
Person in charge at the time of inspection: Mrs Ita Mullan, Registered Nurse	**Date manager registered:** 29 September 2016
Categories of care: Nursing Home (NH) I – old age not falling within any other category DE – dementia PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years Residential Care (RC) I - old age not falling within any other category	**Number of registered places:** 45 A maximum of four residential places in category RC-I and a maximum of 10 patients in category NH-DE.

4.0 Inspection summary

An unannounced inspection took place on 13 July 2017 from 10.05 to 14.25.

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.

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.

The term ‘patients’ is used to describe those living in Glenview, which provides both nursing and residential care.

Evidence of good practice was found in relation tostaff training, the standard of record keeping and the management of pain.

Areas requiring improvement were identified in relation to the availability of medicines and the records in place for the management of distressed reactions.

Patients said that they were “very happy in the home and that staff could not be faulted. The food is too good.”

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.

4.1Inspection outcome

	Regulations	Standards
Total number of areas for improvement	1	*1

*The total number of areas for improvement include one which was stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Ita Mullan, Nurse in Charge, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcementaction did not result from the findings of this inspection.

4.2 Action/enforcementtaken following the most recent follow up premises inspection

Other than those actions detailed in the QIPno further actions were required to be taken following the most recent inspection on 6 June 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 inspectionthe inspector met with two patients, one relative, one care assistant and three registered nurses.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

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
- medicine audits
- care plans
- medicines storage temperatures
- controlled drug record book

Areas for improvements 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 theinspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 6 June 2017

The most recent inspection of the home was an unannounced follow up premises inspection. The draft report and QIP have been issued. The completed QIP has been returned.

6.2 Review of areas for improvement from the last medicines management inspection dated 3 June 2016

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 must ensure that records of administration of emollient preparations and thickening agents by care staff are maintained.	**Met**
	Action taken as confirmed during the inspection: Records for the administration of thickening agents were being recorded on the home's computerised system. Topical medication administration records were being completed by care assistants. These were being reviewed regularly by the registered nurses.	

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 28 **Stated:** First time	Detailed care plans and evidence of multi-disciplinary agreements should be available when medicines are administered in disguised form.	**Met**
	Action taken as confirmed during the inspection: The nurse in charge confirmed that robust systems had been put in place following the last medicines management inspection. Medicines were not currently being administered in disguised form.	
Area for improvement 2 **Ref:** Standard 18 **Stated:** First time	Detailed care plans must be in place when medicines are prescribed to be administered "when required"for the management of distressed reactions. The reason for and outcome of each administration should be recorded on all occasions.	**Not met**
	Action taken as confirmed during the inspection: We examined the management of distressed reactions for four patients. A care plan was in place for only one of these patients. The reason for and outcome of administration were not routinely being recorded. This area for improvement was assessed as not met and has been stated for a 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.

Registered nurses completed training on medicines management via e-learning. In addition medicines management training was provided by the community pharmacist within the last year. The nurse in charge confirmed that competency assessments had also been completed within the last year. Care assistants confirmed that they received regular update training on the use of thickening agents and application of emollients.

The nurse in charge advised that although systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available occasionally medicines did run out of stock. On the day of the inspection three medicines were unavailable; for one of these medicines three doses had been omitted. The nurse in charge had contacted the prescriber and community pharmacist for advice. Whilst it was acknowledged that the prescription had been ordered and there had been delays over the weekend and bank holiday, this is unacceptable. An area for improvement was identified.

There was evidence that 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 to manage changes to prescribed medicines. Personal medication recordswere updated by two registered nurses. This safe practice was acknowledged.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed via e-learning.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and discharge from the home.

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged.

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

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 was evidence that action was taken if the temperature recordings for the refrigerators were outside the accepted range ($2^{o}C$ – $8^{o}C$). Registered nurses were reminded that Glucogel should be stored at room temperature. A small number of out of date medicines were removed from the refrigerators and staff were reminded to closely monitor the expiry dates of medicines.

Areas of good practice

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

Areas for improvement

The registered person shall ensure that medicines are available for administration on all occasions. Where there are issues obtaining medicines the prescriber should be contacted for advice without delay. Ongoing non-administration should be reported to the appropriate authorities, including family, care management and RQIA. An area for improvement was identified.

	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 examined had been administered in accordance with the prescriber's instructions. One medicine which was prescribed for administration on a weekly basis had not been administered on 12 July 2017. This was brought to the attention of the registered nurse for immediate corrective action.

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. However, detailed care plans were not in place for all designated patients. The reason for and outcome of administration were not being recorded on all occasions. There was evidence that the medicines were being administered regularly for a small number of patients; this had not been referred to the prescriber for review. These issues had been raised at the last medicines management inspection but despite the assurance given in the completed QIP, they had not been addressed. An area for improvement was therefore identified for the second time.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place and there was evidence that they were being reviewed regularly. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Pain assessment tools were being used with patients who could not verbalise their pain.

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. Care plans and speech and language assessments were in place. Records of administration were being 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.

Medicine records were well maintained and facilitated the audit process. A small number of hand-written updates on the medication administration records had not been signed by two registered nurses. In addition, there were a few missed signatures for administration. These findings were discussed for close monitoring. Areas of good practice were acknowledged; these included the additional recording sheets for transdermal patches.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several medicines which were not supplied in the blister pack system. In addition, a quarterly audit was completed by a representative of the community pharmacist; an action plan from the most recent audit was available in the treatment room.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping and management of pain.

Areas for improvement

Detailed care plans must be in place when medicines are prescribed to be administered "when required"for the management of distressed reactions. The reason for and outcome of each administration should be recorded on all occasions.

	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 medicines to two patients. The medicines were administered as discreetly as possible and the patients were given time to take their medicines.

Patients were observed to be relaxed and comfortable. Staff were heard chatting to patients in a kind and caring manner.

We spoke with two patients and one relative. They were complimentary about the care and staff in the home.

Fifteen questionnaires were left in the home to facilitate feedback from patients, staff and relatives. Three were returned from patients, one from a relative and four from staff. All responses were positive with regards to the management of medicines.

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.

Policies and procedures for the management of medicines were in place; these were not reviewed. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There were arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspectionwere discussed.Registered nurses were reminded that the non-administration of medicines due tosupply issues needs to be reported. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

Registered nurses confirmed that if discrepancies were identified during the home's auditsthey were investigated and any learning was shared.

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

One of the areas for improvement identified at the last medicines management inspection had been not been addressed effectively. To ensure that areas for improvement 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 would be raised with management. They advised that any resultant action was communicated with staff either individually or through team meetings.

Areas of good practice

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 theQIP were discussed with Mrs Ita Mullan, Nurse in Charge, 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 standardsthis 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 improvementidentified 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 Web Portal for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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:** 13 August 2017	The registered person shall ensure that medicines are available for administration at all times.
	Response by registered persondetailing the actions taken: All efforts are made to ensure that medicines are available for administration at all times with GP aware on this occasion that chemist had medication on order.
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:** Second time **To be completed by:** 13 August 2017	Detailed care plans must be in place when medicines are prescribed to be administered “when required”for the management of distressed reactions. The reason for and outcome of each administration should be recorded on all occasions.
	Response by registered persondetailing the actions taken: Careplans are under ongoing scrutiny to ensure all when reqiired medications are included. Nurses have been reminded of this also.

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

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