The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Dunlarg Care Home

Provider: Healthcare Ireland No 2 Ltd

Date of Inspection: 24 October 2024

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation:	Healthcare Ireland No 2 Ltd
Responsible Individual:	Ms Amanda Mitchell
Registered Manager:	Ms Jennifer Willis
Service Profile: Dunlarg Care Home is a nursing home registered to provide nursing care for up to 50 patients. The home is divided into two units, The Keady Unit and The Armagh Unit. Bedrooms and communal rooms are located over one floor. Patients have access to dining and lounge areas within each unit. A residential care home is attached to the nursing home. The registered manager is responsible for both services.	

2.0 Inspection summary

An unannounced inspection took place on 24 October 2024, from 10.20am to 3.00pm. This was completed by two pharmacist inspectors and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and if the service is well led in relation to medicines management. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Review of medicines management found that improvements in some areas of the management of medicines were necessary including: the auditing systems; the management of distressed reactions; insulin; personal medication records; the storage of controlled drugs and medicines requiring cold storage.

After the inspection, the findings were discussed with the senior pharmacist inspector in RQIA and with Ms Amanda Mitchell, Responsible Individual. RQIA decided that a period of time would be given to implement the necessary improvements. A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained. Failure to implement and sustain the improvements may lead to enforcement.

Full details of the inspection findings, including areas for improvement carried forward for review at the next inspection, and new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.0.

RQIA would like to thank the staff for their assistance throughout the inspection.

3.0 The inspection

3.1 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection information held by RQIA about this home was reviewed. This included areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service and their quality of life

Staff said that they had the appropriate training to look after patients and meet their needs. They said that the team communicated well.

RQIA did not receive any completed patient/family/visitor questionnaires or responses to the staff survey following the inspection.

3.3 Inspection findings

3.3.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments.

The majority of the personal medication records reviewed were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. A small number of discrepancies were highlighted to nurses for immediate corrective action and on-going vigilance.

Copies of patients' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription. However, obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly. An area for improvement was identified.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets etc.

The management of pain and thickening agents was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Directions for use were clearly recorded and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. The reason for and outcome of each administration was not recorded on all occasions when these medicines were administered. An area for improvement was identified.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside of the recommended range. However, directions on the personal medication records for two patients prescribed insulin were unclear or incomplete. This could increase the likelihood of an error occurring. An area for improvement was identified.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined.

An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

3.3.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

Records reviewed showed that the majority of medicines were available for administration when patients required them. One prescribed medicine was out of stock on the day of the inspection. Nurses advised that they had ordered the medicine on time and followed up with the community pharmacy and GP. This was highlighted to the regional manager for review and investigation. An incident report detailing the actions taken to prevent a recurrence was submitted to RQIA on 30 October 2024.

The medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. Review of records evidenced that the temperatures recorded were regularly outside the recommended range and that the thermometer was not always reset correctly. Nurses had not taken appropriate corrective action. An area for improvement was identified.

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

3.3.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of nurses for ongoing monitoring. Records were filed once completed and were readily retrievable for audit/review.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. There were satisfactory arrangements in place for recording of controlled drugs. However, one schedule 2 controlled drug was not stored appropriately in the controlled drug cabinet. An area for improvement was identified.

The audits completed by management and staff had not identified the issues identified at this inspection. The manager should implement a robust audit system which covers all aspects of the management and administration of medicines including those identified. Any shortfalls identified should be detailed in an action plan and addressed. An area for improvement was identified.

3.3.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

A review of records indicated that satisfactory arrangements were in place to manage medicines at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

3.3.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

3.3.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that they staff are competent in managing medicines and that they are supported.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision with staff and at annual appraisal.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	3*	5*

* the total number of areas for improvement includes two which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Jennifer Willis, Registered Manager, Ms Amanda Mitchell, Responsible Individual and the regional manager as part of the inspection process. The timescales for completion commence from the date of inspection.

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:** Immediate and ongoing (24 October 2024)	The registered person shall review the management of insulin to ensure that records of prescribing and administration are clear and complete. Ref: 3.3.1
	Response by registered person detailing the actions taken: Records for prescribing and administration reviewed and rewritten to ensure they are clear and complete. Manager reviews on weekly basis and validation checks have been completed by the Regional Manager and Regional Support Manager. This area of medicine administartion will remain focus for monitoring visits to ensure actions are embedded into practice
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate and ongoing (24 October 2024)	The registered person shall ensure that the maximum, minimum and current temperatures of the medicine refrigerator are monitored and recorded daily, the thermometer is reset and that appropriate action is taken if the temperature recorded is outside the recommended range of 2-8^{o}C. Ref: 3.3.2
	Response by registered person detailing the actions taken: Fridge replaced and manager checks fridge records during daily walkaround
Area for improvement 3 **Ref:** Regulation 13 (1) (a)(b) **Stated:** Second time **To be completed by:** 31 August 2024	The registered person shall review the management of challenging behaviours in the home to include the training of staff and the appropriate record keeping.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 29 **Stated:** First time	The registered person shall ensure that obsolete personal medication records are cancelled and archived. Ref: 3.3.1

To be completed by: Immediate and ongoing (24 October 2024)	**Response by registered person detailing the actions taken:** Archiving of old records has been completed and verified by Regional Manager
Area for improvement 2 **Ref:** Standard 26 **Stated:** First time **To be completed by:** Immediate and ongoing (24 October 2024)	The registered person shall review the management of medicines prescribed 'when required' for distressed reactions to ensure that the reason for and outcome of each administration is consistently recorded. Ref: 3.3.1
	Response by registered person detailing the actions taken: A PRN administration form has been introduced in the home which enables staff to record the effect of PRN medication alongside the administration record.
Area for improvement 3 **Ref:** Standard 31 **Stated:** First time **To be completed by:** Immediate and ongoing (24 October 2024)	The registered person shall ensure that controlled drugs are stored in accordance with the Misuse of Drugs (Safe Custody) (Northern Ireland) Regulations 1973. Ref: 3.3.3
	Response by registered person detailing the actions taken: A second CD cupboard has been installed to allow for the storage of large bottles of liquid medication. Checks of CD storage form part of monitoring visits.
Area for improvement 4 **Ref:** Standard 28 **Stated:** First time **To be completed by:** Immediate and ongoing (24 October 2024)	The registered person shall implement a robust audit system which covers all aspects of the management and administration of medicines. Any shortfalls identified should be detailed in an action plan and addressed. Ref: 3.3.3
	Response by registered person detailing the actions taken: Monthly audits in progress and are further supported by audits completed by providing pharmacy and Regional Support Manager
Area for improvement 5 **Ref:** Standard 21 Criteria (1)	The registered person shall ensure that bowel management is recorded contemporaneously and that actions from any deficits identified are clearly recorded in the patient's daily evaluation records.

Stated: Second time **To be completed by:** 31 July 2024	**Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 2.0

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