Unannounced Medicines Management Inspection Report
22 November 2016

Glendun

Type of Service: Nursing Home
Address: 67 Knocknacarry Road, Cushendun, BT44 0NS
Tel no: 028 2176 1222
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Glendun took place on 22 November 2016 from 10.35 to 15.15.

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 supported the delivery of safe care and positive outcomes for patients. 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. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. No requirements or recommendations were made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Robust arrangements were in place for the management of pain. One area of improvement was identified in relation to care plans regarding distressed reactions and a recommendation was 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 were observed to content in their environment and interactions with staff. No requirements or recommendations were made.

Is the service well led?

The service was found to be well led with respect to the management of medicines. 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. No requirements or recommendations were made.

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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Glendun which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager, Mrs Clare Burke and the registered provider, Mr David Morgan, 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 finance inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 23 August 2016.

2.0 Service details

Registered organisation/registered person: Glendun Nursing Home Ltd/ Mr David Leo Morgan	**Registered manager:** Mrs Clare Burke
Person in charge of the home at the time of inspection: Mrs Clare Burke	**Date manager registered:** 4 June 2015
Categories of care: RC-LD, NH-I, NH-PH, RC-I, RC-MP(E), RC-PH(E), RC-DE	**Number of registered places:** 46

3.0 Methods/processes

Prior to inspection the following records were analysed:

- 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

We met with three patients, one member of care staff, one registered nurse, the activities co-ordinator, the registered manager and the registered provider.

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.

Twenty-five questionnaires were issued to patients, patients' relatives/representatives and staff, with a request that these were completed and returned to RQIA within one week of the inspection.

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 23 August 2016

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

4.2 Review of requirements and recommendations from the last medicines management inspection dated 6 November 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The registered manager must put robust arrangements in place for the management of external preparations.	**Met**
	Action taken as confirmed during the inspection: There were largely satisfactory arrangements in place for the management of external preparations. Some omissions in the medication administration records were noted and discussed. The registered manager advised that this had been identified and she provided details of the plans to address this. Given these assurances the requirement was assessed as met.	

Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must make the necessary arrangements to ensure that all inhaled medicines are being administered in strict accordance with the prescribers' instructions.	**Met**
	Action taken as confirmed during the inspection: An improvement in the administration of inhaled medicines was evidenced.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 38 **Stated:** Second time	The registered manager should ensure that two nurses sign the record of the disposal of medicines.	**Met**
	Action taken as confirmed during the inspection: There was evidence that two registered nurses were involved in the disposal of medicines.	
Recommendation 2 **Ref**: Standard 37 **Stated:** First time	The registered manager should closely monitor the record keeping and administration of warfarin.	**Met**
	Action taken as confirmed during the inspection: Robust arrangements were in place for the management of warfarin. Records were well maintained.	
Recommendation 3 **Ref**: Standard 37 & 39 **Stated:** First time	The registered manager should provide relevant staff with training in the use of the refrigerator thermometer.	**Met**
	Action taken as confirmed during the inspection: Staff had been provided with training on the management of the medicines refrigerator thermometer. There were no further concerns regarding the cold storage of medicines.	

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. There were arrangements in place to provide refresher training in medicines management; recent training included the management of diabetes.

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.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

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. The procedures to monitor other controlled drugs were discussed. It was agreed that monitoring arrangements would be implemented for anxiolytic medicines.

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. 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 for improvement

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

The sample of medicines examined had been administered in accordance with the prescriber's instructions. 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.

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. The reason for and the outcome of administration were recorded. A care plan was maintained for some but not all of the patients' prescribed these medicines. A recommendation was made.

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 assessment 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. Each administration was 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.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration charts for warfarin, insulin, patches, three monthly injections and bisphosphonate medicines. A small number of omissions were observed in the administration records pertaining to external preparations. This had been identified by the registered manager who advised of the plans to change the format and the auditing procedures for these records; and that training was to be provided in the near future.

Practices for the management of medicines were audited throughout the month by the staff and management. A permanent record of the date of opening was maintained to facilitate audit.

Following discussion with the registered manager and staff and a review of the care files, it was evident that when applicable, other healthcare professionals were contacted in response to medicines management.

Areas for improvement

A care plan should be maintained for patients prescribed medicines to manage distressed reactions. A recommendation was made.

Number of requirements	0	**Number of recommendations**	1

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. Medicines were dispensed from their container, immediately prior to administration.

There was evidence that some patients may have their morning medicines administered at a later time as they preferred to stay in bed.

Patients were noted to be enjoying the activities which were being undertaken at the time of the inspection. There was evidence of good relationships with staff.

The patients spoken to were very complimentary about their care in the home and about the 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.

As part of the inspection process, questionnaires were issued to patients, relatives/patients' representatives and staff. Nine patients completed and returned these within the specified timescale. All of the responses were recorded as 'very satisfied' or 'satisfied' with medicines management in the home.

Areas for improvement

No areas for improvement were identified during the inspection.

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 staff.

There were robust 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 inspection were discussed. There was evidence of the action taken and learning implemented following incidents. Staff confirmed that they had been made aware of medicine related incidents.

It was noted that management and staff were very knowledgeable regarding individual patient needs with respect to medicines.

A review of the internal audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

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 advised that management were open and approachable and willing to listen. They stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

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

Areas for improvement

No areas for improvement were identified during the inspection.

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 the registered manager Mrs Clare Burke and the registered provider, Mr David Morgan, 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 the 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	
Recommendations	
Recommendation 1 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 21 December 2016	The registered provider should ensure that a care plan is maintained for patients prescribed medicines on a 'when required' basis for the management of distressed reactions. **Response by registered provider detailing the actions taken:** Care plans are now in place for patients prescribed medicines on a 'when required' basis for the management of distressed reactions.

Please ensure this document is completed in full and returned to the web portal

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