Unannounced Medicines Management Inspection Report
12 September 2016

Rosemount Care Centre

Type of Service: Nursing Home
Address: 2 Moy Road, Portadown, BT62 1QL
Tel No: 028 3833 1311
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Rosemount Care Centre took place on 12 September 2016 from 09.50 to 14:45.

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 most areas of the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines had received training and been deemed competent. However, two requirements in relation to ensuring that medicines were available in the home for administration as prescribed were made.

Is care effective?

The management of medicines supported the delivery of effective care. One area of improvement in relation to the records for distressed reactions was identified and a recommendation was made for the second time.

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. There were no areas of improvement identified.

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. There were no areas of improvement identified.

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 the 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 section 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 Rosemount Care Centre which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Nicola Blair, Nurse in Charge, and Ms Junnita Armstrong, Registered Nurse, on the day of the inspection. The details were also discussed with Ms Claire McKenna, Registered Manager, via telephone call on 15 September 2016. 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 care and premises inspection

There were no further actions required to be taken following the most recent inspection on 8 July 2016.

2.0 Service details

Registered organisation/registered person: Zest Care Homes Limited Mr Philip Scott	**Registered manager:** Ms Jillian Claire McKenna
Person in charge of the home at the time of inspection: Mrs Nicola Blair (Nurse in Charge)	**Date manager registered:** 1 November 2011
Categories of care: NH-DE, NH-I, RC-DE	**Number of registered places:** 73

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 spoke with one care assistant, two senior care assistants and two registered nurses.

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.

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 8 July 2016

The most recent inspection of the home was an announced pre-registration inspection. This was undertaken by the care inspector and estates inspector, following a variation application for the registration of two additional bedrooms within the dementia nursing unit. No requirements or recommendations were made.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 14 January 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13 (4) **Stated:** First time	The registered manager must investigate the discrepancy in the administration of Vagifem pessaries for one patient. The outcome of the investigation including the action to be taken to prevent a recurrence must be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: The investigation was completed and the outcome including the action taken to prevent a recurrence was forwarded to RQIA.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 37 **Stated:** First time	The registered manager should ensure that the reason for each administration and the subsequent outcome are recorded for medicines which are prescribed to be administered 'when required' for the management of distressed reactions.	**Partially Met**
	Action taken as confirmed during the inspection: A review of a sample of medication administration records and daily care notes indicated that the reason and outcome had been recorded on some but not all occasions. This recommendation was stated for a second time.	

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.

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. However, on the day of the inspection it was noted that one medicine had been out of stock for one patient for several days; a satisfactory explanation was not provided. In addition supplies of analgesic medicines had been out of stock for three patients for up to three days. Staff provided assurances that the patients had not been in pain as alternative pain relief was given. Two requirements were made.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and the majority of 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. 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.

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

The registered provider must investigate why a medicine was unavailable for administration for several days. The outcome of the investigation including the action taken to prevent a recurrence must be forwarded to RQIA. A requirement was made.

The registered provider must ensure that medicines are available for administration as prescribed on all occasions. The registered manager must be made aware of all potential out of stocks. A requirement was made.

Number of requirements	2	Number of recommendations	0

4.4 Is care effective?

With the exception of the medicines which had been unavailable, 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. Care plans were in place. The reason for and the outcome of administration were recorded on some but not all occasions. The recommendation which was made at the last medicines management inspection was made for a second time.

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 a pain tool was used as needed. Detailed care plans were in place. Staff also advised that a pain assessment is completed as part of the admission process.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent care plans and speech and language assessment reports were in place. Records of prescribing and administration were maintained. However the required consistency level had not been recorded on all personal medication records, medication administration and recording sheets which were maintained by care assistants. The registered manager advised that this would be addressed.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the separate records for transdermal patches and antibiotic recording sheets.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines, nutritional supplements and inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered nurses and care staff it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas for improvement

The registered manager should ensure that the reason for each administration and the subsequent outcome are recorded for medicines which are prescribed to be administered 'when required' for the management of distressed reactions. A recommendation was made for the second time.

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.

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.

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.

Management audits were not available for review during the inspection. The registered manager confirmed that if a discrepancy is identified during the management audits an investigation would be completed and corrective action taken.

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

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff either individually or at team meetings.

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 Ms Claire McKenna, Registered Manager, via telephone call, 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 the 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 taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to pharmacists@rqia.org.uk 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:** First time **To be completed by:** 12 October 2016	The registered provider must investigate why a medicine was unavailable for administration for several days. The outcome of the investigation including the action taken to prevent a recurrence must be forwarded to RQIA.
	Response by registered provider detailing the actions taken: A full investigation has now been completed. A copy of the investigation report including preventative actions and learning outcomes has been submitted.
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 12 October 2016	The registered provider must ensure that medicines are available for administration as prescribed on all occasions.
	Response by registered provider detailing the actions taken: Received prescriptions for regular medications are thoroughly checked against the order made by the home. Were there is no prescription supplied or a discrepancy in the amount /dose required this is brought o the attention of the GP surgery and evidence of same is held within the home for reference. For items that can be purchased over the counter all nursing and senior care staff have been reminded that our pharmacy will supply these items on request urgently via the home account. An emergency some of money has also been made available in order that over the counter items can be purchased via a local pharmacy if this is a more timely option. All Nursing/Senior care staff have had written reminder to refer any unavailability of medications to the Home Manager or the Nurse in Charge in order to address the situation in a timely manner minimising any ill effects on residents. This area is also a focus of ongoing audit procedures.
Recommendations	
Recommendation 1 **Ref:** Standard 37 **Stated:** Second time **To be completed by:** 12 October 2016	The registered manager should ensure that the reason for each administration and the subsequent outcome are recorded for medicines which are prescribed to be administered 'when required' for the management of distressed reactions.
	Response by registered provider detailing the actions taken: All Nursing and Senior Care staff have had written reminder that in addition to signing for administration of 'when required' medications an explanatory annotation must be made overleaf on the Medicine Administration Record. Staff have also been advised that they are required to record in the daily progress notes or relevant care plan evaluation that a 'when required' medication has been administered, the reason it was required and any outcome it may have had. This area has been added as a focus for ongoing medication and care plan audits.

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address

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