Unannounced Follow Up
Medicines Management Inspection Report
1 February 2019

Ringdufferin Nursing Home

Type of Service: Nursing Home
Address: 36 Ringdufferin Road, Killyleagh, BT30 9PH
Tel no: 028 4482 1333
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 service provider from 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 home that provides care for up to 64 patients with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: M Care (NI) Ltd **Responsible Individual:** Mrs Brenda Frances McKay (Acting – no application required)	**Registered Manager:** Mrs Beverley Ruddell
Person in charge at the time of inspection: Mrs Beverley Ruddell	**Date manager registered:** 27 March 2018
Categories of care: Nursing Home (NH): DE – dementia I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years TI – terminally ill	**Number of registered places:** 64 comprising: • a maximum of 32 patients accommodated in the Dunmore Suite (categories NH-I, NH-PH, NH-PH(E) & NH-TI) • a maximum of 31 patients in category NH-DE accommodated in the Strangford Suite • one named resident receiving residential care (in category RC-DE) accommodated in the Strangford Suite

4.0 Inspection summary

An unannounced inspection took place on 1 February 2019 from 10.10 to 15.05.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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.

As a result of the inspection on 5 October 2018 RQIA was concerned that aspects of the management of medicines were in breach of the regulations. Therefore, a meeting was held with the registered persons to discuss RQIA's intention to serve two failure to comply notices under Regulations 13 (4) (Health and Welfare), and 20 (1) (Staffing) of The Nursing Homes Regulations (Northern Ireland) 2005.

During this meeting, the registered person and registered manager acknowledged the failings and an action plan to address the issues that had been identified during the inspection was submitted by the registered manager. The action plan included details of how the improvements made were going to be monitored to ensure that they were embedded into practice and sustained. Due to the significant progress made since the inspection and the assurance provided, RQIA decided that failure comply notices would not be served. The registered person was requested to submit Regulation 29 reports each month until further notice.

The focus of this inspection was to assess progress with the areas for improvement identified during and since the last medicines management inspection; and to determine if the service was delivering safe, effective and compassionate care and if the service was well led.

As part of this inspection we reviewed:

- the management of thickening agents
- the management of external preparations
- the governance arrangements for medicines management
- the process to confirm patient's medication regimens on admission to the home
- the management of distressed reactions
- the management of medicines which are self-administered
- training and competency assessment

The evidence seen during the inspection indicated that the management of medicines supported the delivery of safe, effective and compassionate care and that the service was well led. The improvements which had taken place were acknowledged. The registered manager was advised that the current level of auditing and support for staff should be continued to ensure that the improvements are sustained.

One area for improvement in relation to the standard of maintenance of the personal medication records was identified.

We spoke with one patient who advised that they were very happy in the home.

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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Beverley Ruddell, Registered Manager, 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.

4.2 Action/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 18 October 2018. Other than those actions detailed in the QIP no further actions were required to be taken. 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 home was reviewed. This included the following:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medication related incidents, it was ascertained that no medication related incidents had been reported to RQIA since the last inspection
- monthly monitoring reports submitted by the acting responsible individual

During the inspection we met with one patient, one senior carer, two registered nurses, the deputy manager and the registered manager.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- medicine audits
- care plans
- training records
- medicine storage temperatures

Areas for improvements identified at the last medicines management inspection were reviewed and 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 the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 18 October 2018

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

6.2 Review of areas for improvement from the last medicines management inspection dated 5 October 2018

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:** Second time	The registered person shall ensure that accurate records for the prescribing and administration of thickening agents are maintained. The recommended fluid consistency should be recorded.	**Met**
	Action taken as confirmed during the inspection: Records of prescribing and administration of thickening agents had been maintained. The recommended fluid consistency was detailed on these records. See Section 6.3	
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** Second time	The registered person shall review and revise the management of external preparations.	**Met**
	Action taken as confirmed during the inspection: Care assistants were responsible for the administration of emollient preparations. Records of administration were maintained. See Section 6.3	
Area for improvement 3 **Ref**: Regulation 13 (4) **Stated:** Second time	The registered person shall ensure that robust governance systems are in place for the management of medicines. Management audits should be completed regularly.	**Met**
	Action taken as confirmed during the inspection: A comprehensive auditing system was now in place. See Section 6.3	

Area for improvement 4 **Ref**: Regulation 20 (1) **Stated:** First time	The registered person shall ensure that registered nurses are trained and competent in the management of medicines.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that all registered nurses received further training on the management of medicines and that competencies were re-assessed following the last medicines management inspection. See Section 6.3	
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:** Second time	The registered person shall ensure that medication regimens are confirmed in writing with the prescriber for all admissions.	**Met**
	Action taken as confirmed during the inspection: We reviewed the management of medicines on admission for two patients. Medication regimens had been confirmed in writing with the prescriber. See Section 6.3	
Area for improvement 2 **Ref**: Standard 18 **Stated:** Second time	The registered person shall ensure that detailed care plans for the management of distressed reactions are in place. The reason for and outcome of each administration should be recorded.	**Met**
	Action taken as confirmed during the inspection: Detailed care plans for the management of distressed reactions were in place for the relevant patients. The reason for and outcome of each administration had been recorded. See Section 6.3	

Area for improvement 3 **Ref**: Standard 28 **Stated:** Second time	The registered person shall review and revise the management of medicines which are self-administered.	**Met**
	Action taken as confirmed during the inspection: The management of medicines which are self-administered had been reviewed and revised. Satisfactory systems were in place. See Section 6.3	

6.3 Inspection findings

The management of thickening agents

We reviewed the management of thickening agents for seven patients. Care plans and speech and language assessments were in place for these patients. Copies of the current speech and language assessments were available for care assistants. The registered nurses and care assistants who we spoke with were knowledgeable about each patient's recommendations. Details of the thickening agents were recorded on the personal medication records and records of administration were maintained. The registered manager audited the management of thickening agents weekly and there was evidence that any discrepancies were highlighted to the registered nurses and care assistants for immediate corrective action.

The management of external preparations

Care assistants were responsible for the administration of emollient preparations. Body maps detailing where the prescribed emollient was to be applied were available for care assistants. Records of administration were recorded in the daily personal care charts. Those reviewed at the inspection had been adequately maintained. The registered manager audited the management of external preparations every two weeks. There was evidence that discrepancies had been identified and discussed with care assistants for ongoing vigilance.

The governance arrangements for medicines management

The registered manager completed weekly audits on the management of medicines for distressed reactions and thickening agents, fortnightly audits on the management of emollients and monthly audits on care plans and self-administered medicines. In addition a monthly medicines management audit was completed. Copies of the audits and action plans to address any shortfalls were available for inspection. The need to continue to closely monitor the management of medicines to ensure that all improvements are sustained was discussed with the registered manager. We also discussed the need to report any medicine related incidents to the prescriber, RQIA and the relevant trusts.

Confirming medication regimens on admission to the home

We reviewed the management of medicines on admission for two patients. One patient had been admitted from hospital, the discharge letter was available for cross-referencing to ensure accuracy. The second patient had been admitted from another care home. A copy of the personal medication record had been received from the previous care home and registered nurses had confirmed these medicines with the patient's general practitioner.

The management of distressed reactions

We reviewed the management of medicines for distressed reaction for several patients. Care plans detailing how the distressed reactions should be managed, including details of any prescribed medicines were in place. The reason for and outcome of each administration was recorded on charts which were available on the medicines file.

The management of medicines which are self-administered

A small number of patients self-administered some of their inhaled medicines. This was recorded in their care plans, the personal medication records and the medication administration records. A record of the transfer of the inhalers to the patients was maintained on the medication administration records.

Training and competency assessment

Registered nurses are employed from a nursing agency. The agency have confirmed that all registered nurses received training on the management of medicines, record keeping and care planning following the last medicines management inspection. Competency assessments were also updated.

Other areas examined

We reviewed the standard of maintenance of the personal medication records. Some records had several amendments and needed to be re-written to minimise the risk of an error occurring. A number of obsolete personal medication records had not been cancelled and archived. For one patient, recently prescribed medicines had been written on an obsolete personal medication record. The registered person should ensure that only the most recent personal medication record is available on the medicines file. Where more than one personal medication record is required, this should be referenced i.e. 1 of 2, 2 of 2.

Areas for improvement

The registered person shall ensure the personal medication records are re-written in a timely manner. Only the current personal medication record should be available on the medicines file.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Beverley Ruddell, Registered Manager, 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 standards this 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 improvement identified 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.

Quality Improvement Plan

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 29 **Stated:** First time **To be completed by:** 3 March 2019	The registered person shall review and revise the standard of maintenance of the personal medication records. Ref: 6.3
	Response by registered person detailing the actions taken: The manager will ensure all historic Kardex's are archived in a timely manner, hospital discharge letters are now filed in care plan notes.

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

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