Unannounced Medicines Management Inspection Report
6 July 2018

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 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 with 64 beds that provides care for 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 and one named resident in category RC-DE accommodated in the Strangford Suite.

4.0 Inspection summary

An unannounced inspection took place on 6 July 2018 from 10.15 to 16.15.

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.

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.

There was evidence of good practice in relation to the management of controlled drugs and the storage of medicines.

We found that the vast majority of medicines were being administered to patients as prescribed.

Areas for improvement were identified in relation to confirming the details of medicines on admission, care planning with regards to medication refusals and adding medicines to food, the management of distressed reactions, thickening agents and external medicines, the medication administration records and the governance arrangements for medicines.

The management of thickening agents and the medication audit systems had been highlighted as areas for improvement at the medicines management inspection on 25 May 2017. The follow up inspection on 14 August 2017 found that these improvements had been made. The findings of this inspection indicate that the improvements had not been sustained. Given this outcome a follow up inspection will be undertaken later in the year.

Patients said that the staff were “very 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.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	4	4

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Beverley Ruddell, Registered Manager, and Mrs Brenda McKay, Responsible Individual (Acting), 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

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 23 March 2018. 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 inspection we met with two patients, two relatives, three care assistants, two registered nurses, the registered manager and the responsible individual (acting).

We provided the registered manager with 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. We also left 'Have we missed you' cards in the foyer of the home to inform patients/their representatives, how to contact RQIA to tell us of their experience of the care provided.

We asked the registered manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

Areas for improvement 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 the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 23 March 2018

The most recent inspection of the home was an unannounced follow up care inspection. The completed QIP was returned and 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 14 August 2017

Areas for improvement from the last medicines management inspection		
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 30 **Stated:** First time	The registered person shall ensure that the temperature of the treatment room on the ground floor is maintained at or below 25^{o}C.	**Met**
	Action taken as confirmed during the inspection: An air conditioning unit was in place. The temperature of the treatment room on the ground floor was being maintained at or below 25^{o}C	

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.

The registered manager advised that medicines were managed by registered nurses who were trained and deemed competent to do so. Training had been provided by the community pharmacist in April 2018. 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 supervision and competency assessment. Competency assessments had been completed with registered nurses in May 2018. It was agreed that the findings of this inspection would be discussed with all registered nurses and care assistants to ensure that they fully understand and sustain the expected practices.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training had been provided.

We reviewed the management of medicines on admission and medication changes. Personal medication records and medication administration records were verified and signed by two registered nurses; this safe practice was acknowledged. For patients admitted from hospital the hospital discharge letter was photocopied and forwarded to the general practitioner. However, when patients were admitted from their own home their medication regimens were not confirmed in writing with the prescriber. An area for improvement was identified.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available. 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.

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. insulin. The use of separate administration charts was acknowledged as good practice.

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

For some patients medicines were added to food to assist their administration due to the patient's swallowing difficulties. It was also evidenced that a small number of patients refuse some of their prescribed medicines. It was acknowledged that registered nurses and management were aware of each patients needs and they advised that family and prescribers were involved in the decision making process. However, detailed care plans and records of the decision making process were not in place to direct this aspect of the care. An area for improvement was identified.

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 of good practice

There were examples of good practice in relation to the storage of medicines and the management of controlled drugs.

Areas for improvement

Medication regimens should be confirmed in writing with the prescriber for all admissions.

Detailed care plans should be in place for the management of medication refusals and the adding of medicines to food to assist administration.

	Regulations	Standards
Total number of areas for improvement	0	2

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. Two discrepancies were discussed with the management team for close monitoring.

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. However, detailed care plans were not in place for all patients and the reason for and the outcome of administration were not recorded. An area for improvement was identified. The management team advised that the management of distressed reactions would be included in the auditing system (See Section 6.7).

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. Care plans were in place and pain assessment tools were used with patients who could not verbalise their pain.

The management of swallowing difficulty was examined. Satisfactory systems were observed in the Strangford suite. In the Dunmore suite staff were knowledgeable regarding each patient's needs in relation to their difficulty in swallowing. However, we found that the personal medication records were not up to date and records of administration by registered nurses and care assistants were not maintained. Accurate records for the prescribing and administration of thickening agents should be maintained. The recommended consistency of any fluid should be accurately recorded. An area for improvement was identified. This aspect of care had been raised previously and addressed appropriately. It was disappointing to note that the improvements had not been sustained throughout the home.

The management of external preparations was reviewed. Registered nurses had recorded on the medication administration records that external medicines, including a number of prescription only medicines, were administered by care assistants and that records of administration were maintained on a separate record. In the Dunmore Suite these records had not been completed. In the Strangford Suite, staff advised that these records had been temporarily misplaced. All records should be readily available for inspection. The management of external medicines should be reviewed and revised. Registered nurses were reminded that they remain accountable for this delegated task and accurate records of administration should be maintained. An area for improvement was identified.

A small number of patients were being facilitated to self-administer some of their medicines; this is commended. However, care plans for this were not in place and there was no record of the transfer of the prescribed medicines to the patients. The personal medication records and medication administration records had not been marked to indicate that the medicines were being self-administered. An area for improvement was identified.

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.

The majority of the medicine records were well maintained and facilitated the audit process. However, improvements in the standard of maintenance of the medication administration records were necessary. There were a small number of missed signatures, the audit outcomes indicated that the medicines had been administered. For two patients medicines had been omitted but the reason for the omissions were not clearly recorded. The registered nurse was able to provide a satisfactory explanation. The reason for all medication omissions should be clearly recorded. An area for improvement was identified.

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

Areas of good practice

There was an example of good practice in relation to the management of pain.

Areas for improvement

Detailed care plans for the management of distressed reactions should be in place. The reason for and outcome of each administration should be recorded.

Accurate records for the prescribing and administration of thickening agents should be maintained. The recommended consistency of any fluids should be recorded.

The reason for the non-administration of prescribed medicines should be accurately recorded.

The management of the administration of external preparations should be reviewed and revised.

The management of medicines which are self-administered should be reviewed and revised.

	Regulations	Standards
Total number of areas for improvement	3	2

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.

The administration of medicines was not observed at the inspection. Staff were knowledgeable about the administration of medicines and relevant guidance was displayed on the medicines file for easy reference.

Throughout the inspection, we found that there were good relationships between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity. It was clear from discussion and observation of staff, that the staff were familiar with the patients' likes and dislikes. Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

The patients spoken to at the inspection, advised that they had no concerns in relation to the management of their medicines and they were happy for the staff to administer their medicines. Comments included:

"The staff are very good. The food is nice and I have no pain."
" I am very happy."

We spoke to two relatives who were complimentary regarding the care and staff in the home.

As part of the inspection process, we issued 10 questionnaires to patients and their representatives, none were returned within the specified timeframe. Any comments from patients, their representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for information and action as required.

Areas of good practice

Discussions with staff indicated that they listened to patients and took account of their views.

Areas for improvement

No areas for improvement were identified.

	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.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. Arrangements were in place to implement the collection of equality data within Ringdufferin Nursing Home.

Written policies and procedures for the management of medicines were in place. These were not reviewed at the inspection.

There were arrangements in place for the management of medicine related incidents. Staff advised 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 learning identified and the action taken to prevent a recurrence. In relation to the regional safeguarding procedures, the registered manager advised that staff were aware that medicine incidents may need to be reported to the safeguarding team.

There was limited evidence that the governance arrangements for medicines management in place were effective or robust. It is disappointing that some of the areas previously identified for improvement and subsequently addressed had not been sustained (see Section 4.0). The registered manager was newly appointed and was being mentored by the previous manager. Registered nurses maintained running balances for several medicines which were not supplied in the monitored dosage system. The monthly management audits which had been in place at the last medicines management inspection had not been sustained. The last management audit had been completed in December 2017. The community pharmacist completed a quarterly audit. We found that the majority of medicines were being administered as prescribed. However, there was evidence that staff were not following the homes policies in relation to, the management of medicines on admission, thickening agents, external medicines and the completion of some care plans. These shortfalls would have been identified and addressed if a robust auditing system, which included all aspects for the management of medicines, had been in place. An area for improvement was identified.

Staff confirmed that any concerns in relation to medicines management which they raised with management were addressed. They advised that management were approachable.

No online questionnaires were completed by staff with the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to identifying learning from medication incidents and implementing action plans to prevent a recurrence.

Areas for improvement

Robust governance systems for the management of medicines should be in place. A robust audit tool which identifies and addresses shortfalls in the management of medicines should be developed and implemented. The audits should be completed frequently.

	Regulations	Standards
Total number of areas for improvement	1	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Beverley Ruddell, Registered Manager, and Mrs Brenda McKay, Responsible Individual (Acting), 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 via the Web Portal for assessment by the inspector.

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:** 6 August 2018	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. Ref: 6.5
	Response by registered person detailing the actions taken: Staff have been instructed to ensure that accurate records should be maintained and that the recommended fluid consistencies are recorded at all times.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 6 August 2018	The registered person shall ensure that the reason for any non-administration of medicines is accurately recorded. Ref: 6.5
	Response by registered person detailing the actions taken: Nurses are to record accurately on the back of MARS and Progress sheet any non administration of medication and the reason why.
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 6 August 2018	The registered person shall review and revise the management of external preparations. Ref: 6.5
	Response by registered person detailing the actions taken: Topical cream sheets are now in place, staff have been instructed to ensure these are accurately completed.
Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 6 August 2018	The registered person shall ensure that robust governance systems are in place for the management of medicines. Management audits should be completed regularly. Ref: 6.7
	Response by registered person detailing the actions taken: Monthly audits have commenced and records are in place.

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 28 **Stated:** First time **To be completed by:** 6 August 2018	The registered person shall ensure that medication regimens are confirmed in writing with the prescriber for all admissions. Ref: 6.4
	Response by registered person detailing the actions taken: Medication for all new admissions will be confirmed in writing.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 6 August 2018	The registered person shall ensure that detailed care plans are in place for the management of medication refusals and the adding of medicines to food to assist administration. Ref: 6.4
	Response by registered person detailing the actions taken: Care plans are in place for refusal of medication and covert administration of medication
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 6 August 2018	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. Ref: 6.5
	Response by registered person detailing the actions taken: Care plans are in place for distressed reactions and records are maintained on the back of MARS for trigger, behaviour and response to PRN meds.
Area for improvement 4 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 6 August 2018	The registered person shall review and revise the management of medicines which are self-administered. Ref: 6.5
	Response by registered person detailing the actions taken: Care plans in place for residents self administration of medication e.g inhalers, insulin, GTN.

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

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