

Unannounced Medicines Management Inspection Report 6 December 2018



Richmond

Type of Service: Nursing Home
Address: 19 Seafront Road, Cultra, BT18 0BB
Tel no: 028 9042 6558
Inspector: Paul Nixon

www.rqia.org.uk

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 that provides care for up to 35 patients with a variety of needs, as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Richmond Nursing Home Ltd Responsible Individual: Mrs Sharon Ruth Radcliffe-Bryans	Registered Manager: Mrs Sharon Ruth Radcliffe-Bryans
Person in charge at the time of inspection: Mrs Sharon Ruth Radcliffe-Bryans	Date manager registered: 1 April 2005
Categories of care: Nursing Homes 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: 35

4.0 Inspection summary

An unannounced inspection took place on 6 December 2018 from 10.05 to 14.25.

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.

Evidence of good practice was found in relation to medicine governance, medicine administration, medicines storage and the management of controlled drugs.

An area for improvement was identified in relation to medicine records which had not been effectively addressed following the previous medicines management inspection and has been stated for a second time.

The patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients we spoke to were positive about the care provided in the home. They were complimentary about the staff and management.

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

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Ms Sharon Ruth Radcliffe-Bryans, 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

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 27 November 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 three patients, two patient's representatives, the registered manager, two nursing sisters and five care staff.

We provided 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA. We left 'Have we missed you' cards in the foyer of the home to inform patients and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of service provision. Flyers which gave information on raising a concern were also left in the home.

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

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
- care plans
- training records
- medicines storage temperatures

The 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 27 November 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be reviewed 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 30 November 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 28 Stated: First time	The registered person shall ensure that arrangements are in place to ensure the safe management of medicines during a patient's admission to the home.	Met
	Action taken as confirmed during the inspection: Two newly admitted patients' records were examined. Appropriate arrangements were in place to ensure the safe management of their medicines since their admission to the home.	

Area for improvement 2 Ref: Standard 29 Stated: First time	The registered person shall ensure that eye medicines are labelled appropriately and the dates of opening recorded.	Met
	Action taken as confirmed during the inspection: The eye medicines examined were labelled appropriately and the dates of opening were recorded.	
Area for improvement 3 Ref: Standard 18 Stated: First time	The registered person shall ensure that the reason for and the outcome of administration of medicines prescribed for administration on a “when required” basis for the management of distressed reactions are recorded.	Not met
	Action taken as confirmed during the inspection: For two patients whose records were examined, the reason for and the outcome of administration of medicines prescribed for administration on a “when required” basis for the management of distressed reactions had mostly not been recorded. This area for improvement was stated for a second time.	

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.

Medicines were managed by staff who had 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. Refresher training in medicines management was provided in the last year.

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. Antibiotics and newly prescribed medicines had been received into the home without delay.

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

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

There were procedures in place to ensure the safe management of medicines during a patient's admission to 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.

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. The medicine refrigerator and oxygen equipment were checked at regular intervals.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission, the management of controlled drugs and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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 medicines prescribed to be administered at atypical intervals 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. A care plan was maintained. 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, as specified in section 6.2, the reason for and outcome of administration were mostly not recorded.

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. A pain assessment tool was used and a care plan was maintained.

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. Administrations were 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.

Medicine records were mostly maintained and facilitated the audit process. Areas of good practice were acknowledged. They included additional records for recording the application and removal of transdermal patches.

Following discussion with the registered manager and staff and examination of care plans, it was evident that other healthcare professionals were contacted, when required, to meet the needs of patients. Staff advised that they had good working relationships with healthcare professionals involved in patient care.

Areas of good practice

There were examples of good practice in relation to the standard of maintenance of most records, care planning and the administration of medicines.

Areas for improvement

No new areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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 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 were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were knowledgeable regarding their patient's needs, wishes and preferences. Staff and patient interaction and communication demonstrated that patients were treated courteously, with dignity and respect. Good relationships were evident between staff and patients.

We spoke with two patients' representatives. One stated that "staff are friendly, helpful, attentive and responsive." The other raised a concern about an aspect of care. This was discussed with the registered manager and nursing sister, who gave a satisfactory explanation regarding the matter and what action was being taken to address it.

The patients we spoke with advised that they were very satisfied with the care provided in the home, including the management of their medicines. They were complimentary regarding staff and management. Comments made included:

- “I receive excellent care and staff are excellent.”
- “Staff are very good and very attentive; the food is good”
- “Staff are very kind and very helpful; food on the whole is good.”

Of the questionnaires that were issued, four were returned from patients or their representatives. The responses indicated that they were very satisfied with all aspects of the care.

Areas of good practice

Staff listened to patients and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	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 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 Richmond.

Written policies and procedures for the management of medicines were in place. These were not examined in detail. Following discussion with staff, it was evident that they were knowledgeable with the policies and procedures and that any updates were highlighted to them.

The governance arrangements for medicines management were reviewed. Management advised of the audits which take place and how areas for improvement were identified and followed up. This was usually through the development of action plans and staff supervision. The audit activity included running stock balances for most of the solid dosage medicines. However, not all of the areas for improvement identified at the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process. Also, the need to record all audit activity was discussed. The registered manager gave an assurance that these matters would be addressed without delay.

There were satisfactory arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. They provided details of the procedures in place to ensure that all staff were made aware of incidents and to prevent recurrence. These usually included reflective practice and supervision. In relation to the regional

safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with the registered manager, and any resultant action was discussed at team meetings and/or supervision. They spoke positively about their work and advised that there were good working relationships in the home with staff, management and with other healthcare professionals. They stated they felt well supported in their work.

No members of staff shared their views by completing an online questionnaire.

Areas of good practice

There were examples of good practice in relation to the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	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 Ms Sharon Ruth Radcliffe-Bryans, 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 via the 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	
<p>Area for improvement 1</p> <p>Ref: Standard 18</p> <p>Stated: Second time</p> <p>To be completed by: 5 January 2019</p>	<p>The registered person shall ensure that the reason for and the outcome of administration of medicines prescribed for administration on a “when required” basis for the management of distressed reactions are recorded.</p> <p>Ref: 6.2</p> <hr/> <p>Response by registered person detailing the actions taken: All RNs given training on the inclusion of PRN medication in the residents' daily notes. Audit sheets added to medicine record files to be completed each time a Registered Nurse gives PRN medication which details: drug, dosage, date and time of administration, reason for administration and outcome. A weekly spot check of PRN medications by Nursing Sisters to check compliance with the above measures.</p>

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



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