Unannounced Medicines Management Inspection Report
30 November 2017

Richmond

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

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 35 beds that provides care for patients with a variety of healthcare needs, as detailed in section 3.0

3.0 Service details

Organisation/Registered Provider: Richmond Nursing Home Ltd **Responsible Individual:** Ms Sharon Ruth Radcliffe-Bryans	**Registered Manager:** Ms Sharon Ruth Radcliffe-Bryans
Person in charge at the time of inspection: Ms Sharon Ruth Radcliffe-Bryans	**Date manager registered:** 01 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 30 November 2017 from 09.45 to 14.20.

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.

Areas requiring improvement were identified include the admission process and medicine records.

The patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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	3

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 required to be taken following the most recent inspection on 3 April 2017.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- 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, the registered manager, two registered nurses and four care staff.

A total of 10 questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views 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

Areas for improvements 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 3 April 2017

The most recent inspection of the home was an unannounced 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 21 November 2016

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**: Regulation 13(4) **Stated:** First time	The registered provider must ensure that robust arrangements are in place for the management of records for patients prescribed thickening agents; records must be fully and accurately maintained.	**Met**
	Action taken as confirmed during the inspection: Two patients' records were examined. In each instance, the thickening agent 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.	

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. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

For two recent admissions, their medication profiles had not been verified with the prescribers. Also, only one registered nurse had been involved in writing the personal medication record. An area for improvement was identified.

There were mostly satisfactory arrangements in place to manage changes to prescribed medicines. However, personal medication records were updated by only one registered nurse. The registered manager gave an assurance that this would be reviewed to ensure that two registered nurses are involved in these updates.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. The registered manager provided recorded evidence that staff had completed safeguarding training.

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. warfarin. 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. The medicine refrigerators and oxygen equipment were checked at regular intervals.

The dates of opening were not recorded on several eye medicine containers. These medicines expire 28 days after opening and, therefore, it is important to record the date of opening in order for the date of expiry to be determined. Also, one eye medicine container was unlabelled. An area for improvement was identified.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessments, controlled drugs and the storage of most medicines.

Areas for improvement

Arrangements should be in place to ensure the safe management of medicines during a patient's admission to the home.

Eye medicines should be labelled appropriately and the dates of opening recorded.

	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 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.

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. A care plan was maintained. However, the reason for and the outcome of administration were generally not recorded. An area for improvement was identified.

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 as needed. A care plan was maintained. Staff also advised that a pain assessment is completed as part of the admission process.

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 generally well maintained and facilitated the audit process. However, several patients did not have their medicine allergy status declared on their personal medication record; the registered manager gave an assurance that this matter would be addressed without delay. The need to promptly file away obsolete warfarin records was discussed.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for most psychoactive medicines.

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. 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 care planning and the administration of medicines.

Areas for improvement

The reason for and the outcome of administration of medicines prescribed for administration on a "when required" basis for the management of distressed reactions should be routinely recorded.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

One resident self-administers some of their medication. There was a risk assessment in place. The need to record this arrangement in the care plan was discussed with the registered manager, who gave an assurance that the matter would be addressed.

The administration of medicines to patients was completed in a caring manner, the patient was given time to take their medicines and medicines were administered as discreetly as possible.

Throughout the inspection, it was 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. From discussion and observation of staff, it was clear that they were familiar with the patients' needs, their likes and dislikes.

The patients we spoke with advised that they were content with the management of their medicines and the care provided in the home. Some comments made were:

"I couldn't complain; care is good; food is excellent; the standard is A++ if not better."
"Care is sufficient; staff are very good."
"Care is excellent; staff are excellent and do everything for us; I am very happy here."

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, we issued questionnaires to patients and their representatives. Three questionnaires were completed and returned within the specified timeframe. Comments received were positive; with responses recorded as 'very satisfied' or 'satisfied' with the management of medicines in the home. One resident stated:

"The whole team is integrated and this is holistic. It brings great credit to them."

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff listening to and valuing patients and taking 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.

Written policies and procedures for the management of medicines were in place. These were not examined.

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. 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.

A review of the audit records indicated that largely satisfactory outcomes had been achieved.

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 management were open and approachable and willing to listen.

Two members of staff and two visiting professionals shared their views by completing an online questionnaire. Comments received were positive; with responses recorded as 'satisfied' with the care in the home.

Areas of good practice

There were examples of good practice in relation to the management of medicine incidents. 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 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 28 **Stated:** First time **To be completed by:** 30 December 2017	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. Ref: 6.4
	Response by registered person detailing the actions taken: All residents have a copy of medicienes prescribed from GP Surgery as stated in our Admission Policy.
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 30 December 2017	The registered person shall ensure that eye medicines are labelled appropriately and the dates of opening recorded. Ref: 6.4
	Response by registered person detailing the actions taken: All eye medicines checked and RN staff reminded to record date when opened.
Area for improvement 3 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 30 December 2017	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. Ref: 6.5
	Response by registered person detailing the actions taken: Care Plans updated to include above and RNs instructed re recording in Care Plans and Daily Statements.

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

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