Unannounced Medicines Management Inspection Report
3 May 2017

Ravenhill

Type of Service: Nursing Home
Address: 79-81 Shore Road, Greenisland, BT38 8TZ
Tel No: 028 9086 2169
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Ravenhill Nursing Home took place on 3 May 2017 from 10.35 to 15.50.

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 the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines were trained and competent. There were largely satisfactory systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. One area for improvement in relation to storage was identified; one recommendation was made.

Is care effective?

Most areas of the management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Care plans in relation to medicines management were in place. Three areas of improvement were identified in relation to record keeping and the administration of medicines. One requirement was stated for a second time and two recommendations were made.

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. The patient consulted with confirmed that they were administered their medicines appropriately and were complimentary regarding the care provided in the home. No requirements or recommendations were made.

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. No requirements or recommendations were made.

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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Ravenhill which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Staff Nurses Lorna Venus, Nurse-in-Charge, the other staff nurses on duty, and Mrs Christine Kim, Registered Manager, by telephone on 4 May 2017. 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 finance inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 8 December 2016.

2.0 Service details

Registered organisation/registered person: Ravenhill Private Nursing Home/ Mr William Trevor Gage	**Registered manager:** Mrs Isabella Christine Kim
Person in charge of the home at the time of inspection: Staff Nurse Lorna Venus	**Date manager registered:** 1 November 2007
Categories of care: RC-I, NH-I, NH-PH	**Number of registered places:** 38

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 met with one patient, three registered nurses, the medical administrative assistant and one visiting professional.

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
- medicines storage temperatures

Fifteen questionnaires were issued to patients, their relatives/representatives and staff, with a request that these were completed and returned within one week of the inspection.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 8 December 2016

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

4.2 Review of requirements and recommendations from the last medicines management inspection 21 June 2016

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	In relation to enteral feeding, the registered provider must make the necessary arrangements to ensure that the fluid intake charts are fully and accurately maintained and there are systems in place to ensure that the daily volume administered meets with the prescribed total.	**Met**
	Action taken as confirmed during the inspection: An improvement in the completion of these records was evidenced at the inspection. They included the total daily fluid intake.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered provider must make the necessary arrangements to ensure that all medicines are administered in strict accordance with the prescriber's instructions.	**Met**

	Action taken as confirmed during the inspection: Most of the medicines examined had been administered as prescribed. A few discrepancies were noted and discussed.	

Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time	The registered provider must put robust arrangements in place for the management of records pertaining to external preparations.	**Partially Met**
	Action taken as confirmed during the inspection: The sample of records examined indicated that some records of administration were incomplete and more detail was required in the records completed by the care staff. A record of the administration of medicines must be fully maintained. **This requirement is stated for a second time**	
Requirement 4 **Ref**: Regulation 13(4) **Stated:** First time	The register provider must review the governance arrangements in the home to ensure that a robust auditing process which covers all aspects of medicines management and readily identifies areas for improvement is developed and implemented.	**Met**
	Action taken as confirmed during the inspection: The auditing system had been reviewed and revised. Daily audits were in place, with the objective that each patient's medicines were audited every month. There was evidence of running stock balances for antibiotics. It was agreed that the completion of records regarding external preparations would be included in the audit process.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 38 **Stated:** Second time	The registered manager should closely monitor the arrangements for the disposal of medicines to ensure that the records are fully maintained on every occasion.	**Met**
	Action taken as confirmed during the inspection: Satisfactory arrangements were in place to record the disposal of medicines.	

Recommendation 2 **Ref**: Standard 28 **Stated:** First time	The registered provider should review the management of medicines which are required to be crushed prior to administration.	**Met**
	Action taken as confirmed during the inspection: The management of medicines which require to be crushed had been reviewed. Details were recorded on the patient's personal medication record and medicine label.	
Recommendation 3 **Ref**: Standard 18 **Stated:** First time	The registered provider should ensure that a care plan is maintained for any patient prescribed medicines on a "when required" basis for the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: There was evidence that care plans regarding the management of distressed reactions were in place. One care plan needed further detail and it was agreed that this would be addressed.	

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. Refresher training in safeguarding, dysphagia and behaviours that challenge was currently being completed by staff and medicines management training was being planned.

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. It was agreed that prescription forms would be stored in a locked cupboard from the day of the inspection onwards.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Antibiotics and new medicines had been received and commenced in a timely manner. Personal medication 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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.
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 some other controlled drugs which is good practice. It was advised that they should also include checks on diazepam, as some of these could not be audited during the inspection.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. However, the room temperature of one medicine storage area was raised and very warm. This was discussed in relation to medicine storage temperatures. A recommendation was made.

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 temperature of one medicine storage area should be monitored and recorded on a daily basis to ensure temperatures do not exceed 25^{o}C. A recommendation was made.

Number of requirements	0	**Number of recommendations**	1

4.4 Is care effective?

Most of medicines examined had been administered in accordance with the prescriber's instructions. A few discrepancies were noted and discussed. It was agreed that these medicines would be closely monitored from the day of the inspection onwards. Some audit trails on laxative sachets could not be concluded due to sharing of containers. Patients must be administered from their own supply of medicines. This should be addressed and a recommendation was made.

There was evidence that time critical medicines had been administered at the correct time. In relation to medicines which were prescribed at weekly or three monthly intervals, there was a list in place to alert staff of the day or date when the medicine was due. However, it was noted that two controlled drugs patches were administered three days late within the last month. This was discussed and daily records were reviewed. There was no evidence that this had affected the patient's pain control. Staff confirmed that ongoing monitoring was in place.

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 (see also Section 4.2). The reason for and the outcome of the administration were not recorded. A recommendation was made.

With the exception of the controlled drug patches as mentioned above, 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 most of the patients could tell staff if they were in pain and for those that couldn't, the staff confirmed that they knew how this would be expressed. A care plan and pain assessment record were 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. Each administration was 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 well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for high risk medicines, transdermal patches, antibiotics and injectable medicines. However, improvement is required in the completion of records for external preparations (see Section 4.2); a requirement was stated for a second time.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to the patient's healthcare needs.

Areas for improvement

The necessary arrangements should be made to ensure that patients are administered medicines from their own supply. A recommendation was made.

A record of the reason for and the outcome of the administration of medicines prescribed on a "when required" basis for distressed reactions should be maintained. A recommendation was made.

The management of external preparations must be reviewed. A requirement was stated for a second time.

Number of requirements	1	**Number of recommendations**	2

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.

Staff provided examples of where some patients would have their medicines later in the morning as they liked to stay in bed for a while. Staff confirmed that this did not impact on the minimum time intervals for medicines which were prescribed throughout the day.

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. It was clear that the staff were familiar with the patients' needs, their likes and dislikes.

The patient spoken to had no concerns regarding the management of their medicines and advised that staff responded in a timely manner to any requests they had made.
The patient was very complimentary about staff and management and the care provided in the home; comments included:

"this is the best home"
"you get to know everyone"
"the staff are great"

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, questionnaires were issued to patients, their relatives/representatives and staff. Three questionnaires were completed and returned. The majority of responses were recorded as 'very satisfied' or 'satisfied' with the management of medicines in the home. One response was recorded as 'unsatisfied' and the comments were in relation to care. These comments were shared with the registered manager by telephone and also the care inspector.

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.

In relation to the regional safeguarding procedures, staff confirmed they were familiar with these and were aware of when incidents must be considered as reportable to the adult safeguarding lead. The name of the organisation's safeguarding champion was listed on the staff notice board.

There were largely satisfactory arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. The late administration of the controlled drug patches had not been considered as reportable and therefore had not been reported. This was discussed with the registered manager for future reference.

A variety of internal auditing systems were in place for medicines management. They included daily, weekly and monthly audits. An overarching monthly audit was completed by the registered manager and in addition audits were completed by the community pharmacist. A review of the internal audit records indicated that largely satisfactory outcomes had been achieved. Where areas for improvement had been identified, these were shared with staff in writing, to read, address and sign.

Following discussion with staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. It was acknowledged that the medical administrative assistant's role continued to enable the registered nurses to spend more time caring for the patients.

The staff spoken to at the inspection were very positive about their work, the good working relationships between staff and the support provided by the staff team and the registered manager. They were very complimentary regarding the leadership in the home and advised that the registered manager was always available and willing to listen.

Not all of the requirements made 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.

Staff confirmed that any concerns in relation to medicines management were raised with management.

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 Mrs Lorna Venus, Nurse in Charge, the registered nurses on duty and the registered manager by telephone on 4 May 2017, 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 to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations 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:** Second time **To be completed by:** 4 June 2017	The registered provider must put robust arrangements in place for the management of records pertaining to external preparations.
	Response by registered provider detailing the actions taken: A template for recording application of external preparations has been introduced. This will be monitored closely to ensure clear accurate recording is maintained. Training for Care staff in the application and recording of use of external preparations has also been introduced.
Recommendations	
Recommendation 1 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 4 June 2017	The registered provider should monitor and record the room temperature of medicine storage areas to ensure temperatures do not exceed 25^{o}C.
	Response by registered provider detailing the actions taken: We willl monitor and record the temperature in the medicine storage area and wi;ll take appropriate action should the temperature exceed 25 degrees C
Recommendation 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 4 June 2017	The registered provider should make the necessary arrangements to ensure that patients are administered medicines from their own supply.
	Response by registered provider detailing the actions taken: We will make the necessary arrangements to ensure that patients are administered medicines from their own supply
Recommendation 3 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 4 June 2017	The registered provider should ensure that a record of the reason for and the outcome of the administration of medicines prescribed on a when required basis for distressed reactions is maintained on every occasion.
	Response by registered provider detailing the actions taken: All nursing staff have been instructed to record the reason for and the outcome of the administration of medicines prescribed on a when required basis for distressed reactions on every occasion they are required. This will be monitored as part of the monthly medicine audit

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

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