Unannounced Medicines Management Inspection Report
21 June 2016

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 took place on 21 June 2016 from 10:25 to16:15.

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?

Most areas of the management of medicines supported the delivery of safe care. Staff were trained and competent and there were safe systems for the management of medicine changes and the management of high risk medicines. One requirement in relation to fluid intake records has been made and one recommendation regarding the crushing of medicines has been made.

Is care effective?

Some areas of the management of medicines supported the delivery of effective care. However it was found that some medicines had not been administered as prescribed and the records had not been accurately maintained. Two requirements have been made; one in relation to the management of external preparations and one in relation to ensuring medicines are administered as prescribed. One recommendation regarding the record keeping for the disposal of medicines has been stated for a second time and one recommendation regarding the management of distressed reactions has been made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Patients spoke positively about the staff and their care in the home. Staff interactions with patients were observed to be compassionate, caring and timely, which promoted the delivery of positive outcomes for patients. There were no areas for improvement identified.

Is the service well led?

The need for improvement in the governance arrangements for medicines management was identified and a requirement regarding the auditing process for medicines management has been made. In considering the findings of the inspection and as areas for improvement were identified, within safe and effective care, these findings would indicate the need to review the management of medicines.

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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to the DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 standards until compliance is achieved. Please also refer to section 4.2 and 5.0 of this report.

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	4	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with the registered manager, Mrs Christine Kim, 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.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 29 February 2016.

2.0 Service details

Registered organisation/registered provider: Mr William Trevor Gage	**Registered manager:** Mrs Isabella Christine Kim
Person in charge of the home at the time of inspection: Mrs Isabella Christine Kim	**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 three patients, two registered nurses, the medical administrative assistant and the registered manager.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector. No one availed of the opportunity.

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
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 29 February 2016

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 their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 4 June 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The registered manager must review the management of self-administered medicines.	**Met**
	Action taken as confirmed during the inspection: At the time of this inspection, patients were not responsible for the self-administration of medicines. The registered manager provided details of the procedures that were in place should this practice be required in the future.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 38 **Stated:** First time	Two nurses should be involved in the transcribing of new medicine entries onto personal medication records. Both staff should initial the entry on every occasion.	**Met**
	Action taken as confirmed during the inspection: From the sample of personal medication records observed, there was evidence that all new medicine entries were signed by two registered nurses. This process had been well embedded into routine practice.	

Recommendation 2 **Ref**: Standard 38 **Stated:** First 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.	**Partially Met**
	Action taken as confirmed during the inspection: A review of the record of the disposal of medicines indicated that signatures from the staff members involved in the disposal and the date of uplift were not always recorded. This recommendation has been partially met and is stated for a second time.	

4.3 Is care safe?

There were systems in place to ensure that the staff had received training in the management of medicines. This included the completion of an induction process 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. The last medicines management training had been provided in June 2014. Due to the inspection findings it was agreed that refresher training in medicines management would be scheduled for the near future.

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.

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

There were largely satisfactory procedures in place to ensure the safe management of medicines during a patient's admission to the home and discharge from the home. For one new patient, written confirmation of the patient's medicine regime had not been obtained; this was requested during the inspection.

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 and insulin. The use of separate administration charts was acknowledged.

The management of medicines administered via an enteral feeding tube was examined. The registered manager confirmed that the staff had received training and policies and procedures were maintained. Examination of fluid intake charts indicated that these had not been fully and accurately maintained. These charts must detail all flushes and when the enteral feed is set up for administration. The fluid intake per 24 hours should be recorded and this volume should be cross referenced with the regime to ensure that the prescribed total daily volume of fluid is administered. A requirement was made.

A small number of medicines were crushed prior to administration. There was written consent for this practice from the prescriber for some but not all of the medicines. There was no evidence that pharmaceutical advice had been obtained regarding the suitability of crushing the medicine. This should be addressed and a recommendation was made.

Discontinued or expired medicines were returned to a clinical waste company for disposal and staff confirmed that controlled drugs were denatured and rendered irretrievable prior to disposal. This was not always clearly recorded on the record of disposal and should be reviewed. Staff were reminded that the supply of zopiclone which was awaiting disposal, was also a Schedule 4 controlled drug and must be denatured prior to disposal.

Due to limited space, the storage of medicines had been reviewed and an additional storage area had been brought into use. All medicines were stored safely and securely and most medicines were stored in accordance with the manufacturer's instructions. A number of medicines which did not require refrigeration were removed from the medicine refrigerator and staff were reminded that insulin pens must be stored at room temperature once opened. Some expired medicines (eye preparations and one nasal spray) were also removed from stock for disposal. Medicine storage areas were clean, tidy and well organised. Medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas for improvement

In relation to enteral feeding, the management of fluid intake charts must be reviewed to ensure that each chart is fully and accurately maintained and there are systems in place to ensure that the daily volume administered meets with the prescribed regime. A requirement was made.

The management of medicines which are required to be crushed prior to administration should be reviewed. A recommendation was made.

Number of requirements	1	Number of recommendations	1

4.4 Is care effective?

The majority of medicines which were examined had been administered in accordance with the prescriber's instructions. However, a significant discrepancy was observed in one liquid medicine and the registered manager agreed that she would investigate this issue and report it to the prescriber. Discrepancies were also observed in inhaled medicines, eye preparations and external preparations; these medicines had not been administered as prescribed. Following discussion with staff, it was concluded that the patient had not been offered some of the eye preparations and inhaled medicines. This was discussed at length during the inspection. All medicines must be administered as prescribed. A requirement was made. There was evidence that time critical medicines had been administered on time. There were arrangements in place to alert staff of when doses of weekly, twice weekly and 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 e.g. anxiolytic medicines, the dosage instructions were recorded on the personal medication record. A care plan was not maintained and a recommendation was made. These medicines were rarely required to be administered. 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. Staff provided an example of were a patient had experienced some distressed reactions and following a review and increase in pain relief, the need for anxiolytic medicines was not required.

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 verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment was completed as part of the patient's admission process.

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. A separate list and folder detailing patients' dietary requirements which included reference to thickened fluids was maintained. The administration was recorded either by the registered nurses or care staff. It was agreed that the fluid intake charts completed by care staff would clearly state the prescribed fluid consistency from the day of the inspection onwards. 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.

Some of the medicines records were well maintained and facilitated the audit process. However, improvement is required in the records pertaining to external preparations. It could not be ascertained if a number of these medicines had been administered as prescribed, as dosage directions and records of administration were not accurately maintained. Dosage directions must be fully recorded for each medicine and discontinued medicines must be clearly marked on personal medication records; specialist regimes must be readily identified and each administration including reasons for non-administration must be recorded on every occasion. A requirement was made. It was also noted that further improvement was necessary in the completion of records for the disposal of medicines. A recommendation has been stated for a second time.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to issues or concerns regarding medicines management.

Areas for improvement

The necessary arrangements must be made to ensure that all medicines are administered in strict accordance with the prescriber's instructions. A requirement was made.

In the instances were medicines are prescribed for the management of distressed reactions, this should be detailed in a care plan. A recommendation was made.

Robust arrangements must be put in place for the management of records pertaining to external preparations. A requirement was made.

The disposal of medicine records should be closely monitored to ensure these include the relevant signatures and dates of disposal and transfer of medicines. A recommendation was stated for a second time.

Number of requirements	2	Number of recommendations	2

4.5 Is care compassionate?

The administration of medicines to patients was observed during the inspection. The staff administered the medicines in a caring manner and patients were given time to take their medicines. There was evidence that medicines were administered in accordance with the patients' preferences in order to maintain dignity and privacy. Staff and patient interaction and communication demonstrated that patients were treated courteously. Good relationships were evident.

The patients spoken to at the inspection stated that they were content with their care in the home and had no concerns regarding the management of their medicines. They advised that staff responded in a timely manner to any requests for medicines e.g. pain relief.

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.

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?

Staff confirmed that written policies and procedures for the management of medicines were in place. The registered manager advised that these were reviewed every six months and any updates were shared with staff as applicable.

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.

Following a review of workload, the registered manager had introduced a new administrative role for a member of staff to assist the registered nurses in October 2015. The introduction of this role has enabled the registered nurses to spend more time caring for the patients. The staff spoke positively in relation to the medical administrative assistant's role.

A review of the internal audit records indicated that a robust auditing process was not in place. Whilst it was recognised that there were monthly audits and running stock balances were maintained for some medicines, the monthly audits focused on tablets and capsules. As there were discrepancies in liquid medicines, inhaled medicines, eye preparations and external preparations, the auditing process should be reviewed to ensure that it covers a variety of medicines and is effective in identifying areas for improvement. A requirement was made. It was reiterated that all medicines must be administered as prescribed and records must be up to date and accurate at all times.

Following discussion with the registered manager, registered nurses and administrative staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Not all of the recommendations 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. They advised that any resultant action was communicated through individual meetings or team meetings.

Areas for improvement

A robust auditing process for the management of medicines must be developed and implemented. A requirement was made.

Number of requirements	1	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Christine Kim, Registered Manager, 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 taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to *pharmacists@rqia.org.uk* for review 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:** First time **To be completed by:** 21 July 2016	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. **Response by registered provider detailing the actions taken:** This has been discussed with nursing staff and will be monitored by the nurse manager to ensure that fluid balance charts are completed giving full details of the volume and type of enteral feeds, all flushes before and after feeds and medication administrations and totalled at the end of the 24 hour period
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 21 July 2016	The registered provider must make the necessary arrangements to ensure that all medicines are administered in strict accordance with the prescriber's instructions. **Response by registered provider detailing the actions taken:** This has been discussed with nursing staff and will be monitored more robustly on an ongoing basis by the Nurse Manager. A training up-date on the Management of Medicines has been arranged for all nursing staff in September 2016
Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 21 July 2016	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:** Training on the use of external applications and the importance of good record keeping has been arranged for care staff. A separate file has been put in place for the recording of external applications. This will be monitored by nursing staff as a part of their ongoing medicine auditing .
Requirement 4 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 21 July 2016	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. **Response by registered provider detailing the actions taken:** The Nurse Manager will continue to audit medications on a monthly basis, covering all apsects of medicines management. In addition to this a peer auditing system has been set in place whereby medications of all residents will be audited thoroughly on an ongoing basis by the Staff Nurses.

Recommendations	
Recommendation 1 **Ref**: Standard 38 **Stated:** Second time **To be completed by:** 21 July 2016	The registered manager should closely monitor the arrangements for the disposal of medicines to ensure that the records are fully maintained on every occasion.
	Response by registered provider detailing the actions taken: Records for the disposal of medications will now be included in the Nurse Manager's monthly medicine audit to ensure they are fully maintained
Recommendation 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 21 July 2016	The registered provider should review the management of medicines which are required to be crushed prior to administration.
	Response by registered provider detailing the actions taken: This has been discussed with nursing staff and any patient requiring medications to be crushed for administration via PEG tube has had a care plan put in place. GPs have been contacted for written authorisation to crush medications and to request if any of the medications can be prescribed in liquid form
Recommendation 3 **Ref**: Standard 18 **Stated:** First time **To be completed by:** 21 July 2016	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.
	Response by registered provider detailing the actions taken: Patients who have been prescribed medicines for management of distressed reactions have been identified and a care plan for each of them put in place which will be reviewed on a monthly basis or more frequently if required

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