Unannounced Medicines Management Inspection Report
17 October 2016

Rylands

Type of Service: Nursing Home
Address: 11 Doagh Road, Kells, Ballymena, BT42 3LZ
Tel no: 028 2589 2411
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Rylands took place on 17 October 2016 from 10.15 to 14.40.

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 had been trained and deemed competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. No requirements or recommendations were made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure that patients were receiving their medicines as prescribed. Care plans in relation to medicines management were in place, they included anticoagulants, pain management, distressed reactions, swallowing difficulty. No requirements or 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. Patients consulted with confirmed that they were administered their medicines appropriately. 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. There were systems which enabled 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 Rylands which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Valerie Rutherford, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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 7 July 2016.

2.0 Service details

Registered organisation/registered person: Rylands/ Mr Trevor Duncan and Mrs Karen Duncan	**Registered manager:** Mrs Valerie Rutherford
Person in charge of the home at the time of inspection: Ms Perla Balmes, Deputy Manager, until 12.30 and Mrs Valerie Rutherford thereafter	**Date manager registered:** 24 March 2014
Categories of care: NH-DE, NH-I, RC-I, RC-MP(E), RC-PH(E), NH-PH, NH-PH(E), NH-LD	**Number of registered places:** 59

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 two patients, one member of senior care staff, one registered nurse, the deputy manager and the registered manager.
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
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 July 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 6 January 2015

There were no requirements of recommendations made as a result of the last medicines management inspection.

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. In the last year, refresher training included the management of diabetes, dysphagia and dementia care. The most recent training was in relation to general medicines management and enteral feeding.

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 procedures in place to ensure the safe management of medicines during a patient's admission to the home and discharge from 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. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. anticoagulants and insulin.

Appropriate arrangements were in place for administering medicines in disguised form.

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. Medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

Most of the 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. One audit discrepancy was identified and shared with management, who provided assurances that this medicine would be closely monitored.

A staff communication book was maintained and viewed at each shift change. This included information regarding medicines and the outcomes of visits from/consultations with other healthcare professionals.

Although there were arrangements in place to alert staff of when doses of twice weekly, three times weekly, weekly or three monthly medicines were due, it was found that one controlled drug patch had not been administered as prescribed and this had resulted in one missed dose. A review of the administration records indicated that two administrations of controlled drug patches had not been signed on the administration records for the current medicine cycle. This was discussed with the registered manager who provided a reason for the missed dose and that this dose and the non-completion of records was an oversight. It was acknowledged that the records of the administration of other controlled drugs had been accurately maintained. It was agreed that she would raise this with the staff responsible for medicines management.

With the exception of the administration records detailed above, medicine records were well maintained and readily facilitated the audit process. The use of separate administration records for antibiotics, medicines for distressed reactions, injectable medicines, pain relief and warfarin was acknowledged.

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. The reason for and the outcome of administration were recorded. A care plan was maintained.

With the exception of the controlled drug patch 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. The reason for and outcome of administration were recorded. 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.

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. There was evidence of the specific administration of medicines arrangements in place for some patients.

Practices for the management of medicines were audited throughout the month by staff and management. This included running stock balances for several medicines. This good practice was acknowledged. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, and a review of care files, it was evident that when applicable, other healthcare professionals such as the prescriber, pharmacist, dietician and specialist nurses, were contacted in response to medicine related concerns or queries.

Areas for improvement

No areas for improvement were identified during the inspection.

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

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.

The patients spoken to advised that they were satisfied with the manner in which their medicines were managed and administered. They advised that staff responded in a timely manner to any requests for medicines e.g. pain relief. They spoke positively about the staff. 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?

There was evidence that the improvements noted at the last medicines management inspection were now well embedded into routine practice. A review of the internal audit records indicated that satisfactory outcomes had been achieved. Staff advised of the procedures that would be undertaken following the identification of a discrepancy.

Written policies and procedures for the management of medicines were in place. These had been reviewed this year. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents.

Following discussion with the registered manager and staff, it was evident that they 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 any resultant action was communicated with staff individually and at supervision.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews