Unannounced Medicines Management Inspection Report
17 November 2016

Rivervale Country

Type of Service: Nursing Home
Address: 56a Dunamore Road, Cookstown, BT80 9NT
Tel no: 028 8675 1787
Inspector: Judith Taylor

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Rivervale Country took place on 17 November 2016 from 10.15 to 14.50.

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 systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. 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 patients were receiving their medicines as prescribed. Care plans regarding specific areas of medicines management were in place. Areas of improvement were identified in relation to record keeping 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. 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. 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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with the Registered Manager, Ms Helena O'Neill, 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 4 August 2016.

2.0 Service details

Registered organisation/registered person: Rivervale Country/ Ms Helena Margaret O'Neill & Ms Cecilia Theresa O'Neill	**Registered manager:** Ms Helena Margaret O'Neill
Person in charge of the home at the time of inspection: Ms Helena Margaret O'Neill	**Date manager registered:** 1 April 2005
Categories of care: RC-DE, RC-I, RC-MP(E), RC-PH(E), RC-MP, RC-PH, NH-DE, NH-I, NH-PH, NH-PH(E), NH-MP, NH-MP(E)	**Number of registered places:** 20

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the incident register: it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

We met with two patients, one patient's relative, one member of care staff 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.

Sixteen questionnaires were issued to patients, relatives/patients' representatives and staff, with a request that they were returned within one week from the date of 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 4 August 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 on 26 November 2015

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The registered manager must develop and implement a robust auditing process which covers all aspects of medicines management.	**Met**
	Action taken as confirmed during the inspection: A significant improvement in the governance arrangements for the management of medicines was evidenced at the inspection. A variety of medicines were audited at regular intervals.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37 **Stated:** First time	The registered manager should review and revise the management of anxiolytic/antipsychotic medicines which are prescribed on a 'when required' basis, to ensure the relevant records are maintained.	**Met**
	Action taken as confirmed during the inspection: A review of the care files and medicine records indicated that the relevant records were maintained for anxiolytic/antipsychotic medicines which were prescribed on a 'when required' basis.	

Recommendation 2 **Ref**: Standard 4 **Stated:** First time	The management of pain should be reviewed to ensure that a pain assessment is completed for all new patients and where pain controlling medicines are prescribed, this is detailed in a care plan.	**Met**
	Action taken as confirmed during the inspection: There was evidence of pain assessments and care plans regarding pain management.	

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 supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was usually provided on an annual basis.

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 and handwritten entries on medication administration 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.

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. 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.

Staff were reminded that the controlled drug cabinet must only be used for the storage of controlled drugs.

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?

The majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. A few discrepancies were observed and discussed. The registered manager provided assurances that she would closely monitor the administration of these medicines.

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 weekly or 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, 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. These medicines were rarely administered. The registered manager advised that the reason for and outcome of any administration was recorded. A care plan was maintained.

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. The good practice of recording the reason for and the outcome of the administration of each dose of analgesic was acknowledged. A care plan was maintained. The registered manager advised that a pain assessment was completed as part of the admission process.

The management of swallowing difficulty was examined. When a thickening agent was prescribed, this was not always recorded on the personal medication record and for one patient there was no stock. Staff were reminded that a supply of this medicine must be in use for each patient prescribed this medicine and sharing of medicines is not acceptable. The registered manager ordered stock during the inspection and advised that the patient's personal medication record would be updated with immediate effect. 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.

Most of the medicine records were well maintained and facilitated the audit process. Some improvements were necessary in the management of personal medication records, as a number of obsolete records required archiving, photographs were missing and there were several misspelt names of medicines. It was also noted that there were missing signatures on the medicine administration records. Two recommendations were made.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines. In addition, a quarterly audit was completed by a representative from the community pharmacy.

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

Areas for improvement

The management of personal medication records should be reviewed to ensure that:

- obsolete records are discontinued and archived
- there is accurate spelling of each medicine, in particular, typed entries
- photographs are in place for all patients

A recommendation was made.

The administration of medicines should be reviewed with staff to ensure that a record of all administration is maintained. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

The administration of medicines to patients was completed in a caring manner and medicines were administered as discreetly as possible. Medicines were prepared immediately prior to their administration from the container in which they were dispensed. Patients were given time to swallow each medicine.

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Patients were treated courteously, with dignity and respect. Good relationships were evident.

The patients and visitor spoken to at the inspection were complimentary about their care/relative's care in the home and had no concerns regarding the management of their medicines.

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, 16 questionnaires were issued to staff, patients and relatives/patients' representatives. Three relatives/patients' representatives, three staff and one patient completed and returned the questionnaires. The responses were positive and these were recorded as 'very satisfied' or 'satisfied' with the management of medicines in the home.

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. The registered manager advised that these were under review and development. 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 and advised of the procedures in place to investigate and report incidents, and implement any learning.

A review of the internal audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the 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 at daily handover and individually.

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 the Registered Manager, Ms Helena O'Neill, 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 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 RQIA web portal 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	
Recommendations	
Recommendation 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 17 December 2016	The registered provider should ensure that the areas identified for improvement in the personal medication records are addressed and the improvements sustained.
	Response by registered provider detailing the actions taken: Medication records have been reviewed and updated in accordance with recommendations. Obsolete records have been archived in patient's records. Photographs have been updated and any misspellings have been corrected. Staff have been instructed to monitor files and update frequently in accordance with the recommendations.
Recommendation 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 17 December 2016	The registered provider should ensure that records of administration are accurately maintained.
	Response by registered provider detailing the actions taken: Auditing of medicine records will be maintained to ensure all administration of medicines are recorded and signed for. Staff will continue to received training in this area.

Please ensure this document is completed in full and returned to the RQIA web portal

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