Unannounced Medicines Management Inspection Report
26 June 2017

Rivervale Country

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

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 20 beds that provides care for adults with a variety of care needs.

3.0 Service details

Organisation/Registered Provider: Rivervale Country **Responsible Individuals:** Ms Helena Margaret O'Neill & Miss 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: <u>Nursing Home (NH)</u> I - Old age not falling within any other category DE - Dementia MP - Mental disorder excluding learning disability or dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH - Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years <u>Residential Care (RC)</u> I - Old age not falling within any other category DE - Dementia MP - Mental disorder excluding learning disability or dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH - Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 20 comprising: - a maximum of 3 persons in residential categories. - no more than 1 resident in category RC-DE - no more than 5 patients in category NH-DE

4.0 Inspection summary

An unannounced inspection took place on 26 June 2017 from 10.35 to 14.20.

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.

The term 'patients' is used to describe those living in Rivervale Country which provides both nursing and residential care.

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 medicines administration, most medicine records and the storage of medicines.

An area for improvement was identified in relation to the completion of the controlled drug record book.

The patient consulted with was complimentary about the care provided in the home.

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	1

Details of the Quality Improvement Plan (QIP) were discussed with Ms Helena O'Neill, Registered Manager/Provider, 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

The most recent inspection of the home was an unannounced care inspection undertaken on 6 February 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

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

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of incidents: it was ascertained that no incidents involving medicines had been 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 the inspector met with one patient, one member of care staff, the registered manager/provider and the co-registered provider.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

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

Areas for improvement 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 6 February 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 17 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**: Standard 29 **Stated:** First time	The registered provider should ensure that the areas identified for improvement in the personal medication records are addressed and the improvements sustained.	**Met**
	Action taken as confirmed during the inspection: The sample of personal medication records which were examined had been maintained in the required manner. The patient's photograph was attached to the record.	

Area for improvement 2 **Ref**: Standard 29 **Stated:** First time	The registered provider should ensure that records of administration are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: A sample of medication administration records completed by registered nurses and care staff were examined. These had been accurately maintained.	

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 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. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed in November 2016.

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.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and the management of medicines changes.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. However, one area for improvement was identified. It was noted that some entries on the pages were incomplete. The information had been recorded in a separate record which was used to complete the daily stock checks on these medicines. Whilst there were no discrepancies noted in the stock balances, staff must ensure that the controlled drug record book is fully maintained. Balances must be brought to zero when the complete supply has been disposed of or transferred.

Largely satisfactory arrangements were in place for the disposal of discontinued or expired medicines. On most but not all occasions, only one member of staff had signed the record. Two staff should be involved in the disposal and both should sign the record. The registered manager provided assurances that this would be addressed with staff. It was acknowledged that two staff were involved in the denaturing and disposal of controlled drugs.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were 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.

Oxygen equipment and medicine refrigerators were checked at regular intervals. It was noted that there had been some recent issues with the medicine refrigerator temperatures and the action taken was recorded.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessments, the management of medicines on admission and the storage of medicines.

Areas for improvement

The completion of the controlled drug record book should be monitored to ensure it is fully maintained.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Most of the medicines, including liquid medicines, were supplied in the 28 day monitored dosage system. With the exception of one medicine, the sample of other medicines examined had been administered in accordance with the prescriber's instructions. The registered manager advised that this medicine would be closely monitored.

There was evidence that time critical medicines had been administered at the correct time. Arrangements were in place to alert staff of when doses of alternate day, weekly or three monthly medicines were due.

The management of pain, distressed reactions and swallowing difficulty were examined. The medicine details were recorded on the patients' personal medication records and in their care plans. Records of administration were maintained.

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 the maintenance of protocols for 'when required' medicines and double signatures for the writing and updating of personal medication records and medication administration records.

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 health care needs.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

The administration of medicines to one patient was observed at the inspection. 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. It was clear that the staff were familiar with the patients' needs, their likes and dislikes.

The patient we met with spoke positively about their care and the management of their medicines. They were complimentary regarding staff and management. Comments included:

"they couldn't be better"
"they look after you well"
"food lovely"

Of the questionnaires that were issued, five were returned from patients, five from patients' representatives and five from staff. The responses indicated that they were very satisfied/satisfied with all aspects of the care in relation to the management of medicines.

Areas of good practice

There was evidence that staff listened to patients and relatives and took 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 under review and development. Management advised that they would be shared with staff in due course.

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

The auditing procedures for medicines management were reviewed. A new system had been developed and implemented to ensure that running stock balances were maintained for all medicines which were not supplied in the 28 day blister packs. This good practice was acknowledged. The registered manager provided details of the action taken if a discrepancy occurred.

Following discussion with the registered manager and 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. They also stated that there were good working relationships within the home and with healthcare professionals involved in patient care.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, the management of medicine incidents and quality improvement. 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 Helena O'Neill, Registered Manager/Provider, as part of the inspection process. The timescales commence from the date of inspection.

The registered manager/provider 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 providers 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 providers should confirm that these actions have been completed and return the completed QIP 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 31 **Stated:** First time **To be completed by:** 26 July 2017	The registered person shall ensure that the controlled drug record book is fully maintained. Ref: 6.4
	Response by registered person detailing the actions taken: This matter has been formally discussed with staff, and a learning alert issued. Staff have been reminded of the importance of maintaining the Controlled Drug Record Book, and have been retrained in order to do so correctly.

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

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