Unannounced Medicines Management Inspection Report
11 February 2019

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 that provides care for up to 20 patients living with healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Rivervale Country **Responsible Individuals:** Helena Margaret O'Neill and Cecelia Theresa O'Neill	**Registered manager:** Helena O'Neill
Person in charge of the home at the time of inspection: Helena O'Neill	**Date manager registered:** 1 April 2005
Categories of care: Nursing Home (NH): DE - Dementia I - Old age not falling within any other category 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 TI - Terminally ill	**Number of registered places:** 20 including: no more than 5 patients in category NH-DE

4.0 Inspection summary

An unannounced inspection took place on 11 February 2019 from 10.35 to 16.00.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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 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 staff training and competency assessment, the administration of most medicines and the security of medicines.

Areas for improvement were identified in relation to the completion of medicine records, including controlled drugs, the storage of medicines and governance arrangements for medicines.

The patient and relative we met with spoke positively about the staff and the care provided. There was a warm and welcoming atmosphere in the home and the patients were observed to be relaxed and comfortable in their environment.

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	4	*3

*The total number of areas for improvement includes one, in relation to the standards, which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with the registered persons, Helena O'Neill and Theresa 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 7 July 2018. 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 medicine related incidents: it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

A poster was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

During the inspection we met with one patient, one relative and the registered persons. We also met briefly with a group of registered nurses who were attending training in the home.

We provided 10 questionnaires to distribute to patients and their representatives, for completion and return to RQIA and we asked the registered manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

A sample of the following records was examined during the inspection:

- medicines received
- personal medication records
- medicine administration records
- medicines disposed of
- controlled drug record books
- medicine audits
- 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 7 July 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was 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 26 June 2017

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 31 **Stated:** First time	The registered person shall ensure that the controlled drug record book is fully maintained.	**Partially met**
	Action taken as confirmed during the inspection: Examination of the controlled drug record book indicated that some staff signatures regarding administration were missing. This area for improvement has been stated for a second time.	

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.

The registered manager advised that all staff managing medicines had been trained and deemed competent to do so. Staff competency assessments were completed following induction, annually or more frequently as required. The impact of training was monitored through team meetings, supervision and annual appraisal. A record of training and competency was maintained. Refresher training was being provided on the day of the inspection and included the administration of thickening agents. Other planned training included the management of enteral feeding.

There were largely satisfactory procedures in place to ensure the safe management of medicines during a patient's admission to the home and for the management of medicine changes. Written confirmation of medicine regimes and any medicine changes were obtained. Personal medication records were updated by two trained staff. This is safe practice and was acknowledged. However, this did not occur for handwritten entries on medication administration records. See Section 6.5.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. We were advised of the procedures to identify, report and follow up any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay.

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

The management of controlled drugs was reviewed. Safe systems were in place for storage and stock reconciliation checks. A review of the controlled drug record book indicated that some signatures regarding administration were missing. The need to ensure that a second person is involved in recording the receipt of new supplies was discussed. The area for improvement is stated for a second time.

We reviewed the management of high risk medicines e.g. insulin. Written confirmation of the dosage regime was in place and was clearly detailed on the medicine records.

Discontinued or expired medicines including controlled drugs were disposed of appropriately. The use of a separate disposal record for controlled drugs was acknowledged.

Medicines were stored safely and securely and storage areas were organised. Oxygen and blood monitoring equipment were checked on a regular basis. In relation to the cold storage of medicines, daily medicines refrigerator temperatures were being monitored and recorded, and were within the accepted range; however, we noted that there was a build-up of ice in the medicines refrigerator and some medicines had not been rotated regarding new supplies. Medicines with a limited shelf-life once opened were in current use and were marked with the date of opening; one eye preparation was removed from stock as it had passed the expiry date and one eye preparation required cold storage. An area for improvement was identified.

Areas of good practice

There were some examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and high risk medicines.

Areas for improvement

One area for improvement regarding controlled drugs has been stated for a second time.

The storage of medicines should be reviewed to ensure that stocks are rotated; eye preparations are monitored and the medicines refrigerator is defrosted at regular intervals.

	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 were supplied in a monitored dosage system (MDS). Audits on these medicines produced satisfactory outcomes.

We could not complete a small number of audit trails on medicines which were not supplied in the MDS; therefore we were unable to confirm that these medicines had been administered as prescribed. In addition, we could not ascertain if one medicine remained prescribed and had been omitted in error, or had been discontinued. The registered manager must investigate this and provide details to RQIA. An area for improvement was identified.

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.

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. Details of pain assessments were available in the medicines folder. A care plan was maintained.

The administration of medicines via an enteral feeding tube was examined. Written confirmation of the dosage regime was in place and details of the administration of the enteral feed, medicines and flushes were recorded.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record, but did not include details of the fluid consistency level. The need for this was discussed and we agreed it would be documented. Records of administration included the fluid consistency level. Care plans and speech and language assessment reports were in place.

The registered manager confirmed that patients were compliant with their medicine regimes and systems were in place to report any concerns to the prescriber.

We examined several medicines records and found that improvements were necessary. A number of the personal medication records were not up to date with respect to prescribed doses and details regarding discontinued medicines; the date of writing was not recorded, and a recent photograph was not in place for a small number of patients. We also noted some spelling mistakes in the printed entries. These records may be used by other healthcare professionals and must be kept up to date and accurate. An area for improvement was identified.

In relation to the medication administration records, most of these were printed. However, when handwritten, the start date was not recorded, two staff had not signed new medicine entries and there was non-correlation between these records and the corresponding personal medication records. There were missing signatures in some records and we were unable to locate some medication administration records to complete the audits. The need for good filing systems was discussed. Two areas for improvement were identified.

Areas of good practice

There were some examples of good practice in relation to the administration of most medicines and pain management.

Areas for improvement

The registered manager must investigate the observation made regarding one medicine and report the findings and action taken.

Personal medication records must be kept fully and accurately maintained.

Records of administration must be kept fully and accurately maintained.

A system should be developed to ensure correlation between the personal medication records and corresponding medication administration records.

	Regulations	Standards
Total number of areas for improvement	3	1

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 patients was not observed during the inspection.

We noted the warm and welcoming atmosphere in the home. Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

We met with one patient who spoke positively about the care provided, the food and the staff. The patient stated that staff responded to any requests in a timely manner. Comments included:

- “Everything is good. You couldn’t get better.”
- “I’m happy enough and the food is A1.”

We also spoke with one relative who expressed her satisfaction with her experience of the home, how well staff looked after her relative and the standard of care and food provided.

Of the questionnaires which were left for patients/patients' representatives, six were returned within the specified time frame (two weeks). The responses were recorded as very satisfied with the care in the home and each included a comment, as detailed below (note: xxx refers to a patient):

"All aspects of care excellent."
"Very happy with care given to xxx, she is very content here."
"All my xxx needs, requirements are catered for perfectly well."
"I would like to emphasise my deep appreciation of the care my xxx receives at this home! Genuinely."
"xxx care is excellent. Nursing home is a lovely homely place. All staff are brilliant."
"My xxx gets great care at Rivervale."

Areas of good practice

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.

We discussed the arrangements in place in relation to the equality of opportunity for patients and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of patients. We were advised that there were arrangements in place to implement the collection of equality data.

The governance arrangements for medicines management were examined. Whilst we acknowledged that there was a variety of auditing systems in place, which included daily, weekly and monthly audits by staff and management, these were not effective in identifying areas for improvement. The inspection findings show that improvements are necessary in the domains of safe and effective care. A robust auditing system must be developed. An area for improvement was identified. The benefit of using the QIP within the audit process was highlighted.

Written policies and procedures for the management of medicines were in place. Management advised that there were systems in place to ensure that staff were made aware of any changes.

We were advised of the arrangements in place to manage medicine related incidents and ensure that staff were made aware and to prevent recurrence. The registered manager also advised that staff knew that incidents may need referral to the safeguarding team.

The registered manager advised that the staff were familiar with their roles and responsibilities in relation to medicines management. We were informed that any concerns were shared at the time with the registered manager and also discussed at daily shift handover.

Three online questionnaires were completed by staff within the specified time frame (two weeks). Positive responses were recorded and two comments were made:

"I believe the residents are getting the best quality of care possible. The staff and management are great."

"The care the patients receive in this home is second to none. They are treated so well and everyone is always so happy. Laughter can always be heard throughout the home. Management take great pride in delivering the best care possible."

Areas of good practice

There were some examples of good practice regarding the management of medicine incidents and there were clearly defined roles and responsibilities for staff.

Areas for improvement

A robust auditing system must be developed and implemented.

	Regulations	Standards
Total number of areas for improvement	1	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 the registered persons, Helena O'Neill and Theresa O'Neill, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager 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 provider 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 provider should confirm that these actions have been completed and return the completed via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 13 March 2019	The registered person shall investigate the observation made regarding one medicine and provide details of the outcomes and action taken. Ref: 6.5
	Response by registered person detailing the actions taken: In relation to the observation above, this was investigated with the GP practice. This medicine was discontinued following the results of blood tests taken previous, and which were received by the GP on the 11 February 2019. GP advised to check bloods in relation to this medication in two months time. 11 April 2019, and they will review this medication pending results at that time. Staff have been informed and retrained.
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 13 March 2019	The registered person shall ensure that personal medication records are kept fully and accurately maintained as detailed in the report. Ref: 6.5
	Response by registered person detailing the actions taken: Staff have received Administration of Medicines training on 25th February 2019 and staff were re educated to ensure that personal medication records are fully and accurately maintained. A new auditing system has been put in place to ensure this practice is maintained.
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 13 March 2019	The registered person shall ensure that medication administration records are kept fully and accurately maintained as detailed in the report. Ref: 6.5
	Response by registered person detailing the actions taken: Administration of Medications training has taken place. Staff have been instructed in the importance of maintaining full and accurate records. This has also been included in the auditing process to ensure compliance.

Area for improvement 4 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 13 March 2019	The registered person shall develop and implement a robust auditing system for medicines management. Ref: 6.7
	Response by registered person detailing the actions taken: A new auditing system has been implemented to ensure that the management of medicines is robust.
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:** Second time **To be completed by:** 13 March 2019	The registered person shall ensure that the controlled drug record book is fully maintained. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken: Staff have been re educated following this inspection and during training that they must have two signatures when receiving and recording controlled drugs into the home,The controlled drugs register must always be maintained with two signatures.
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 13 March 2019	The registered person shall closely monitor the storage of medicines as detailed in the report. Ref: 6.4
	Response by registered person detailing the actions taken: The storage of medicines shall be closely monitored and staff have been trained in this area.
Area for improvement 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 13 March 2019	The registered person shall develop a system to ensure correlation with personal medication records and corresponding medication administration records. Ref: 6.5
	Response by registered person detailing the actions taken: Staff have been educated during training of the importance of ensuring correlation with personal medication records and corresponding medication administration records.

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

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