Inspection Report
10 August 2020

Rathmena House Care Home

Type of Service: Nursing Home
Address: 26 Rathmena Gardens, Ballyclare, BT39 9HU
Tel No: 028 9332 2980
Inspector: Paul Nixon

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 this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a registered nursing home which provides care for up to 29 patients.

2.0 Inspection focus

This inspection focused on medicines management within the service. There were no areas for improvement identified since the last medicines management inspection.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to patients
- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept.

The following records were examined and/or discussed during the inspection:

- care records for two patients requiring a modified diet
- care records for two patients prescribed regular analgesia
- care records for three patients prescribed medication for administration on a “when required” basis for the management of distressed reactions
- care records for one patient who was administered medicines through a feeding tube
- medicines management training and competency assessment records for a sample of staff
- personal medication records
- medicine administration records

- medicine receipt and disposal records
- controlled drug record book
- audits.

3.0 Service details

Organisation/Registered Provider: MD Healthcare Ltd **Responsible Individual:** Ms Lesley Catherine Megarity	**Registered Manager and date registered:** Mrs Lesley McKillen 6 November 2019
Person in charge at the time of inspection: Mrs Lesley McKillen	**Number of registered places:** 29 Not more than four persons in categories NH-LD and NH-LD(E) to be accommodated at any one time.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. LD – Learning disability. LD (E) – Learning disability – over 65 years. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years. Residential Care (RC) I – Old age not falling within any other category.	**Number of patients accommodated in the nursing home on the day of this inspection:** 21

4.0 What has this service done to meet any areas for improvement made at or since the last medicines management inspection on 30 October 2017 and care inspection on 30 January 2020?

There were no areas for improvement made at or since the last medicines management or care inspections.

5.0 What people told us about this service

On the day of inspection we spoke to several staff on duty. They said that they had received good training in relation to personal protective equipment (PPE) and the safety measures that had been implemented in relation to the Covid-19 pandemic. They said that the patients were well looked after and expressed satisfaction with how the home was managed. The also said that they had the appropriate training to look after patients and meet their needs.

Good interactions were observed between staff and patients. Staff were warm and friendly and knew the patients well.

Feedback methods also included a staff poster and paper questionnaires which were provided to the registered person for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. Six questionnaires were completed within the timeframe for inclusion in this report. The respondents indicated that they were satisfied/very satisfied with all aspects of care.

5.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in care homes should be registered with a general medical practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs may change and therefore their medicines should be regularly monitored and reviewed. This may be done by the GP or the pharmacist.

All patients in the home were registered with local GPs and medicines were reviewed and dispensed by the community pharmacist.

Personal medication records were in place for each patient. These contained a list of all prescribed medicines with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals e.g. medication reviews, transfers to hospital.

The records examined had all been fully and accurately completed. In line with best practice, a second member of staff had checked and signed these records when they were updated to provide a double check that they were accurate.

Copies of patients' prescriptions were retained in the home so that any entry on the personal medication record could be checked against the prescription. This again contributes to confidence that the systems in place are safe.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Care plans were in place and directions for use were clearly recorded on the personal medication records. These medicines were rarely used.

Satisfactory systems were in place for the management of thickening agents and medicines administered through a feeding tube.

5.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines must be available to ensure that they are administered to patients as prescribed and when they require them. It is important that they are stored safely and securely and disposed of promptly so that there is no unauthorised access.

The records inspected showed that medicines were available for administration when patients required them. The registered manager advised that there was a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

On arrival at the home the medicines storage area was observed to be securely locked. It was tidy and organised so that medicines belonging to each patient could be easily located. The medicines currently in use were stored within medicine trolleys that were also securely stored so that there could be no unauthorised access. Controlled drugs were stored in the controlled drug cabinet. When medicines needed to be stored at a colder temperature, they were stored within the medicines refrigerator and the temperature range of this refrigerator was monitored each day.

Medicines disposal was discussed with the registered manager. Medicines for disposal are placed into designated waste bins which are uplifted when necessary by a waste disposal contractor. Disposal of medicine records were examined and had been completed so that medicines could be accounted for.

5.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) when medicines are administered to a patient. A sample of these records was reviewed which found that they had been fully and accurately completed. The completed MARs are filed once completed.

The registered manager audits medicine administration on a monthly basis. The audits showed that medicines had been given as prescribed.

Audits completed during this inspection also showed that medicines had been given as prescribed.

The date of opening was recorded on most medicines so that they could be easily audited; this is good practice. However, several insulin pens did not have the date of opening recorded; this practice is necessary both to ensure that the insulin pens are not used beyond their recommended shelf-life and also to facilitate the auditing of their use by management. The

registered manager provided evidence that this matter had been noted during a recent audit and that she had spoken to the nursing staff regarding it.

5.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

This element was not reviewed during this inspection.

5.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident.

The audit system in place helps staff to identify medicine related incidents. The registered manager was familiar with the type of incidents that should be reported.

There had been several medication related incidents identified since the last medicines management inspection. There was evidence that the incidents had been investigated and learning had been shared with staff. The incidents had been reported to the prescribers for guidance and to the appropriate authorities including RQIA.

5.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered manager has a responsibility to check that staff are competent in managing medicines and that staff are supported.

Staff in the home had received a structured induction which included medicines management when that forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

6.0 Evaluation of Inspection

This inspection sought to assess if the home was delivering safe, effective and compassionate care and if the service was well led.

The outcome of this inspection concluded that patients and their relatives can be assured that medicines are well managed within the home. No areas for improvement were identified.

We would like to thank the patients and staff for their assistance throughout the inspection.

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

The Regulation and Quality Improvement Authority

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

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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