

Unannounced Medicines Management Inspection Report 12 January 2017



Rathmena House Care Home

Type of Service: Nursing Home
Address: 26 Rathmena Gardens, Ballyclare, BT39 9HU
Tel no: 028 9332 2980
Inspector: Rachel Lloyd

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Rathmena House Care Home took place on 12 January 2017 from 10.45 to 14.15.

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. 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 patients were receiving their medicines as prescribed. 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. 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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to DHSSPS Nursing Homes Minimum Standards, February 2008.

For the purposes of this report, the term 'patients' will be used to describe those living in Rathmena House Care Home 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 Wendy McMaster, 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 10 January 2017.

2.0 Service details

Registered organisation/registered person: MD Healthcare Ltd Mrs Lesley Catherine Megarity	Registered manager: Mrs Wendy McMaster
Person in charge of the home at the time of inspection: Mrs Wendy McMaster	Date manager registered: 3 April 2013
Categories of care: NH-PH, NH-PH(E), RC-I, NH-LD, NH-LD(E), NH-I Not more than four persons in categories NH-LD and NH-LD(E) to be accommodated at any one time	Number of registered places: 29

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, 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.

Twenty-five questionnaires were issued to patients, patients' relatives/representatives and staff, with a request that these were completed and returned to RQIA within one week 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 10 January 2017

The most recent inspection of the home was an unannounced post-registration care inspection. The completed QIP will be assessed by the care inspector when it is returned. 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 dated 7 October 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 Ref: Regulation 13(4) Stated: First time	The registered person must review the recording on the MARs of medicines prescribed to be administered 'when required' in order to ensure that the entry is always clear and unambiguous.	Met
	Action taken as confirmed during the inspection: Procedures had been changed since the last inspection. Separate sheets for recording the reason for the administration of 'when required' analgesia and anxiolytics have been introduced, making medicine administration record sheets (MARs) clearer and easier to audit.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 Ref: Standard 37 Stated: First time	The registered person should ensure that the recording system in place for all patients who are prescribed 'when required' anxiolytic and antipsychotic medicines for the treatment of distressed reactions includes detailed care plans and the recording of the reason for and outcome of each administration.	Partially Met
	Action taken as confirmed during the inspection: For the sample of records examined, a care plan was in place. The reason for and the outcome of administration were recorded in the majority of the examples. Although it was acknowledged that these medicines were used infrequently, it was agreed with the registered manager that these details should be recorded in a consistent manner. The registered manager was already addressing this and for this reason the recommendation was not restated.	
Recommendation 2 Ref: Standard 37 Stated: First time	The prescribers should be requested to review those topical medicines which are prescribed for regular application but which are only being used on a 'when required' basis.	Met
	Action taken as confirmed during the inspection: The registered manager stated that these reviews had taken place following the last inspection. The examples examined were being managed appropriately.	

4.3 Is care safe?

Medicines were managed by staff who had 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. The most recent training was in relation to anaphylaxis.

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 medicine 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. Examination of the controlled drug record book indicated that recently, when part of an ampoule was not required, the quantity discarded was not always recorded appropriately. The deputy manager confirmed that the contents had been safely disposed of and that this issue was already being addressed with registered nurses. 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. warfarin and insulin. The use of separate administration charts was acknowledged.

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
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4.4 Is care effective?

The sample of 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. There were arrangements in place to alert staff of when doses of weekly, monthly 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. The reason for and the outcome of administration were usually recorded. Staff were advised to record these details in a consistent manner on every occasion. 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. A care plan was maintained. Staff also advised that a pain assessment was completed as part of the admission process.

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. 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.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. These included the use of transdermal patch application records.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several medicines and nutritional supplements. In addition, a quarterly audit was completed by the community pharmacist. Staff were advised that carrying forward the balance of remaining stock on the medicines administration record sheet on every occasion, would further facilitate audit for medicines not supplied in the monitored dosage system.

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

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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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 were complimentary about their care in the home and 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.

As part of the inspection process, questionnaires were issued to patients, relatives/patients’ representatives and staff. No questionnaires were returned within the specified timescale.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. 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. The medicine related incident reported since the last medicines management inspection was discussed. There was evidence of the action taken and learning implemented following incidents.

A review of the 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 registered manager and deputy manager, 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.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0
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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.



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