Unannounced Medicines Management Inspection Report
7 February 2017

Rathowen

Type of Service: Nursing Home
Address: 118 Portadown Road, Tandragee, Craigavon, BT62 2JX
Tel no: 028 3884 0226
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Rathowen took place on 7 February 2017 from 11.00 to 13.45.

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 largely in compliance with legislative requirements and standards. Areas for improvement were identified in relation to handwritten entries on medicine administration records, the management of the controlled drug record book and the disposal of medicines. Three 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 largely well led with respect to the management of medicines, recent changes in management have taken place and this was acknowledged. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. Policies and procedures should be reviewed and revised as necessary, to ensure they reflect current procedures for all areas of medicines management within the home. One recommendation was 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 described those living in Rathowen which provides both nursing and residential care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with the registered nurse in charge, Ms Aileen Preston, 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 finance inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 29 November 2016.

2.0 Service details

Registered organisation/registered person: Mr Desmond Joseph Watt	**Registered manager:** See below
Person in charge of the home at the time of inspection: Ms Aileen Preston (Registered Nurse)	**Date manager registered:** Ms Charlene Parkin Acting – no application
Categories of care: RC-I, NH-I	**Number of registered places:** 19

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; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with two patients and the registered nurse in charge.

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 29 November 2016

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was returned and was approved by the finance inspector. This QIP will be validated by the finance inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 5 November 2014

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 includes detailed care plans and the documentation of the reason for and outcome of administration.	**Met**
	Action taken as confirmed during the inspection: In each of the records examined, a care plan was in place and the reason for and outcome of administration was recorded appropriately.	

Recommendation 2 **Ref:** Standard 37 **Stated:** First time	The registered person should ensure that the arrangements for the management of medicines are regularly audited in order to ensure ongoing compliance with legislative requirements and minimum standards.	**Met**
	Action taken as confirmed during the inspection: Since the last medicines management inspection a monitored dosage system for the supply of most medicines had been introduced. Running balances were being maintained for several medicines not contained within this system. The community pharmacist also undertakes an audit every three months. A management audit, resulting in an action plan, had also taken place monthly until October 2016. The registered nurse on duty advised that the new manager intended to continue with this arrangement.	

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 appraisal. Competency assessments were completed annually. Training in the past year had included the management of the new monitored dosage system, anaphylaxis and the management of syringe drivers.

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 were updated by two registered nurses. This safe practice was acknowledged. It was recommended that handwritten entries on medicine administration records should also be checked and signed by a second competent member of staff.

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. There was often only one signature recorded for each administration of a controlled drug and some entries in the controlled drug record book were not in chronological order, causing some stock balances to appear inaccurate. Whilst it was acknowledged that only one registered nurse may be on duty, a second competent member of staff should witness and sign each administration. The management of the controlled drug record book should be reviewed. A recommendation was made.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. The use of separate administration charts was acknowledged.

The disposal of discontinued and expired medicines was examined. Some controlled drugs in Schedule 3 and Schedule 4 (Part 1) had not been denatured and rendered irretrievable prior to disposal. Entries in the record of disposal of medicines had not always been signed by a witness. The disposal of medicines should be reviewed. A recommendation was made.

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 most medicines with a limited shelf life, once opened. It was discussed and agreed that the date of opening should be recorded on all insulin pen devices. There were a number of gaps in recent refrigerator temperature records. The registered nurse on duty advised that a new thermometer had already been ordered since the current one appears inaccurate and this accounts for the gaps in records recently. It was agreed that temperatures would be reviewed and recorded on a daily basis.

Areas for improvement

Handwritten entries on medicine administration records should be checked and signed by a second competent member of staff. A recommendation was made.

The management of the controlled drug record book should be reviewed to ensure that entries are in chronological order and that a second competent member of staff witnesses and signs each administration. A recommendation was made.

The disposal of medicines should be reviewed to ensure that controlled drugs are denatured prior to disposal as appropriate, and that a second competent member of staff is involved and signs the record of disposal for all medicines. A recommendation was made.

Number of requirements	0	Number of recommendations	3

4.4 Is care effective?

The sample of medicines examined had mostly been administered in accordance with the prescriber's instructions. A small number of unexplained omissions and/or missing signatures were noted and discussed.

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 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. A care plan was maintained.

The registered nurse on duty 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 largely 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 usually audited throughout the month by the staff and management. This included running stock balances for several medicines. In addition, a quarterly audit was completed by the community pharmacist. It was discussed and agreed that the date of opening should be recorded on every medicine for audit purposes e.g. laxative sachets, and that the remaining balance of any medicine not included in the monitored dosage system should be carried forward at the start of each new medicine cycle.

Following discussion with the registered nurse on duty 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

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 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

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. These were dated December 2008 and there was no evidence that these had been regularly reviewed and updated as necessary, with the exception of Standard Operating Procedures for Controlled Drugs, dated February 2013. The home's policies and procedures should be reviewed and revised as necessary to ensure they reflect current procedures for all areas of medicines management within the home. A recommendation was made.

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

A review of the audit records maintained until October 2016 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. The registered nurse on duty advised that the new manager intended to continue with this arrangement.

Following discussion with the registered nurse on duty, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management and that any concerns in relation to medicines management were raised with management.

Areas for improvement

Policies and procedures should be reviewed and revised as necessary to ensure they reflect current procedures for all areas of medicines management within the home. A recommendation was made.

Number of requirements	0	Number of recommendations	1

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 nurse in in charge, Ms Aileen Preston, 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 the 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 the 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:** 9 March 2017	The registered provider should ensure that handwritten entries on medicine administration records are checked and signed by a second competent member of staff.
	Response by registered provider detailing the actions taken: The issues raised in this report will be discussed at a staff meeting on or before 10/4/17. With regards medical administration records all handwritten entries will be checked and signed by a second nurse. This can be completed at each staff handover as necessary. it is the intention of the Acting Nurse Manager to audit this weekly and action any deficits.
Recommendation 2 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 9 March 2017	The registered provider should ensure that the management of the controlled drug record book is reviewed to ensure that entries are in chronological order and that a second competent member of staff witnesses and signs each administration.
	Response by registered provider detailing the actions taken: From receipt of the inspection report the controlled drugs record book will have all entries in chronological order. A second signature will be provided by a competent person, who has witnessed and countersigned each administration of any controlled drug. This will be discussed further at the trained staff meeting. This also will be audited weekly by the Acting Nurse Manager.
Recommendation 3 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 9 March 2017	The registered provider should ensure that the disposal of medicines is reviewed to ensure that controlled drugs are denatured prior to disposal and that a second competent member of staff is involved and signs the record of disposal for all medicines.
	Response by registered provider detailing the actions taken: A denaturing kit has been sourced from Medicare Pharmacy - Staff will be shown how to use this at the Staff Meeting. Moving forward, it will be explained that a second competent member of staff must be involved in the correct disposal of medicines and the recording of same. This also will be audited weekly by the Acting Nurse Manager.
Recommendation 4 **Ref**: Standard 28 **Stated:** First time **To be completed by:** 7 May 2017	The registered provider should ensure that policies and procedures are reviewed and revised as necessary to ensure they reflect current procedures for all areas of medicines management within the home.
	Response by registered provider detailing the actions taken: All policies and the corresponding procedures involved in the management of medicines within the home will be reviewed and revised to reflect current procedures by May 7th

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

The Regulation and Quality Improvement Authority

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