Unannounced Medicines Management Inspection Report
22 September 2016

Rockfield Care Centre

Type of Service: Nursing Home
Address: Windmill Road, Newry, BT34 2QW
Tel no: 028 3026 9546
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Rockfield Care Centre took place on 22 September 2016 from 10.45 to 14.20.

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. 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.

For the purposes of this report, the term ‘patients’ will be used to described those living in Rockfield Care Centre 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 Ciara Power, 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 7 June 2016.

2.0 Service details

Registered organisation/registered person: Burnview Healthcare Ltd Mrs Briege Agnes Kelly	**Registered manager:** Mrs Ciara Power
Person in charge of the home at the time of inspection: Mrs Ciara Power	**Date manager registered:** 31 March 2014
Categories of care: NH-I, RC-I, NH-MP, NH-PH	**Number of registered places:** 34

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 spoke with one patient, three care assistants, two registered nurses 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.

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 7 June 2016

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 their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 27 October 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that robust systems are put in place when medicines are discontinued.	**Met**
	Action taken as confirmed during the inspection: Robust systems were observed. Records of correspondence were maintained. Two registered nurses verified and signed updates on the personal medication records and medication administration records. Discontinued medicines were removed from use.	
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that the refrigerator thermometer is reset each day after the maximum, minimum and current temperatures have been recorded.	**Met**
	Action taken as confirmed during the inspection: Registered nurses sign to confirm that the thermometer is being reset each day.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 37, 38 **Stated:** First time	In the interests of safe practice hand-written entries on the medication administration records should be verified and signed by two registered nurses.	**Met**
	Action taken as confirmed during the inspection: Hand-written updates on the medication administration records had been verified and signed by two registered nurses.	
Recommendation 2 **Ref:** Standard 37 **Stated:** First time	The registered manager should maintain a list of the names, signatures and initials of care staff who have been trained to administer thickening agents and external preparations.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that this list was in place and was currently being updated due to new staff.	

4.3 Is care safe?

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 team meetings, supervision and annual appraisal. Competency assessments were completed annually. Records were available for inspection.

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. Registered nurses sign a pro-forma after each medicine round to confirm that all medicines had been administered as prescribed, records were accurately completed and stock was available.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two registered nurses. Discontinued medicines had been removed from the trolley. 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. 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. the administration of medicines via the enteral route.

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

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 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. Care plans were in place for three of the four patients whose records we reviewed; a care plan for the fourth patient was put in place before we left the home. The reason for and the outcome of administration were recorded in the daily care notes on most occasions. The registered manager advised that a revised recording system would be put in place to readily facilitate the maintenance of these records.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were maintained. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff advised that pain assessment tools were used with patients who could not verbalise their pain.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent care plans and speech and language assessments were in place. Records of prescribing and administration, including the required consistency level, 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. Computerised personal medication records had recently been brought into use. They had been verified and signed by two registered nurses.

Practices for the management of medicines were audited throughout the month by staff and management. This included running stock balances for several medicines which were not contained within the blister pack system, including inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to medication related issues.

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?

We spoke with one patient who confirmed that she was happy with the care provided in the home and that she could request additional pain relief if required.

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.

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 had recently been updated following the change in ownership of the home. They were currently being discussed with staff and implemented.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were 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, registered nurses and care 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 any resultant action was communicated with staff either individually or via team meetings.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

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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