Unannounced Medicines Management Inspection Report
12 March 2018

Rockfield Care Home

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

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 with 34 beds that provides care for patients with a range of care needs as identified in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Burnview Healthcare Ltd **Responsible Individual(s):** Mrs Briege Agnes Kelly	**Registered Manager:** See box below
Person in charge at the time of inspection: Ms Luz (Agnes) Jainar – Manager	**Date manager registered:** Ms Luz (Agnes) Jainar – Acting – no application required
Categories of care: Nursing Homes (NH): I – old age not falling within any other category MP – mental disorder excluding learning disability or dementia PH – physical disability other than sensory impairment	**Number of registered places:** 34 A maximum of two persons in category NH-MP and a maximum of eight persons in category NH-PH.

4.0 Inspection summary

An unannounced inspection took place on 12 March 2018 from 10.45 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.

This inspection was undertaken following the unannounced care inspection on 22 February 2018. RQIA was concerned that the quality of care within Rockfield Care Home was below the standard expected with regard to record keeping, auditing and governance arrangements. the prevention, detection and treatment of pressure ulcers. A serious concerns meeting was held with the registered person on 28 February 2018. During the meeting some assurances were provided to RQIA as to how the concerns would be addressed. An action plan was submitted following the meeting providing further assurances as to how the concerns would be managed. A follow up care inspection to validate compliance with the issues identified will be planned. Senior management within RQIA requested that a medicines management inspection be carried out. This unannounced inspection was undertaken to ensure that the management of medicines was in compliance with the relevant legislation and standards. In particular, the standard of record keeping, auditing and governance systems with regards to medicines management were examined.

At the start of the inspection the manager advised that she had already identified that there were shortfalls in the management of medicines. Competency assessments were planned to be completed with all registered nurses.

Four areas for improvement in relation to the standard of maintenance of the personal medication records and the medication administration records, the management of potential out of stocks and the auditing systems were identified.
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	0

Details of the Quality Improvement Plan (QIP) were discussed with Ms Agnes Jainar, Manager, as part of the inspection process and with Mrs Briege Kelly, Registered Person, via telephone call, 13 March 2018. 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

In addition to the actions detailed in the QIP a serious concerns meeting was held with the registered person and manager in RQIA following the most recent care inspection.

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

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection we met with two registered nurses, the deputy manager and the manager.

Ten questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

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
- medicine audits
- care plans
- training records

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 22 February 2018

The most recent inspection of the home was an unannounced care inspection. The QIP will be reviewed by the care inspector when it is returned and 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 18 September 2017

There were no areas for improvement identified as a result of the last medicines management inspection.

6.3 Inspection findings

Personal Medication Records

We reviewed several personal medication records in detail. The personal medication records had been verified and signed by two registered nurses at the time of writing. However, updates on the personal medication records had been signed by only one registered nurse. Some currently prescribed medicines had not been entered on the records and where medicines had been discontinued this had not been recorded on all occasions. Personal medication records must be up to date. Entries should be verified and signed by two registered nurses. An area for improvement was identified.

Administration of Medicines

We reviewed several medication administration records (MARs) in detail. In addition medication administration records were reviewed as part of the random audits which were carried out on the administration of medicines. The majority of hand-written entries on the MARs had not been verified and signed by two registered nurses and on some occasions the date of administration was not clearly recorded. There were a number of missed signatures on the MARs; the audit outcomes from the dates of opening of the medicines indicated that the medicines had been administered even though staff had failed to record the administration. Conversely for two laxative medicines and five inhaled medicines registered nurses had signed that these medicines had been administered when the audits evidenced that they had not.

MARs must be accurately maintained. Hand-written updates should be verified and signed by two registered nurses. The date of administration must be clearly recorded. An area for improvement was identified with regards to the MARs and an area for improvement with regards to the auditing system was also identified (see below).

The management of medicines via the enteral route was examined. The audits which were completed produced satisfactory outcomes. There was evidence that the recommended daily fluid intake was being achieved. Registered nurses were reminded that the daily fluid intake chart should be totalled each day.

The management of distressed reactions was reviewed for three patients. Care plans were in place however they did not provide details of prescribed medicines. The reason for and outcome of the administration had been recorded in the daily progress notes on most occasions. The deputy manager provided assurances that the care plans would be updated following the inspection and hence an area for improvement was not identified.

Availability of prescribed medicines

Two medicines were observed to be out of stock on the day of the inspection. One of the medicines was an analgesic which was prescribed to be administered "when required". The deputy manager confirmed that the patient had not been in pain. However, it is unacceptable for the medication to be unavailable. For the second medicine one dose had been omitted. The manager was requested to ensure that these medicines were made available without delay. Medicines must be available for administration as prescribed. Any ongoing issues should be reported to management and the prescriber. An area for improvement was identified.

Governance

The auditing system for the management of medicines was reviewed. It was acknowledged that audits on a small number of medicines were completed each month and that running stock balances were maintained for some medicines. However, the findings of this inspection indicate that a robust auditing system must be developed and implemented. The audits should include all areas for the management of medicines including the personal medication records, medication administration records, care plans, and audit trails on the administration of medicines. Immediate corrective action should be taken to address any shortfalls. An area for improvement was identified.

Areas of good practice

The registered person had ensured that an experienced manager was in the home in order to provide stability for patients and staff and to address the issues that had recently been identified in relation to care practices and the management of medicines in the home.

Areas for improvement

Personal medication records should be up to date and reflect the prescribers' most recent directions. Updates should be verified and signed by two registered nurses.

Medication administration records must be accurately maintained.

Medicines must be available for administration as prescribed on all occasions.

A robust audit tool must be developed and implemented. Shortfalls in the management of medicines must be identified and addressed. Registered nurses must be made aware of their accountability with regards to ensuring that medicines are administered as prescribed on all occasions.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Agnes Jainar, Manager, and Mrs Briege Kelly, Registered Person, 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:** 12 April 2018	The registered person shall ensure that personal medication records are up to date. Ref: 6.3
	Response by registered person detailing the actions taken: Residents Medication records are now updated.
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** 12 April 2018	The registered person shall ensure that medication administration records are accurately maintained. Ref: 6.3
	Response by registered person detailing the actions taken: Nurses are reminded to ensure that all medication administered are accurately signed for/recorded in MARsheets as per NMC Code of Conduct. This is being stictly monitored.
Area for improvement 3 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** 12 April 2018	The registered person shall ensure that medicines are available to be administered as prescribed on all occasions. Ref: 6.3
	Response by registered person detailing the actions taken: All residents medication are available for administration as prescribed.
Area for improvement 4 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** 12 April 2018	The registered person shall develop and implement a robust audit tool to identify and address any shortfalls in the management and administration of medicines. Ref: 6.3
	Response by registered person detailing the actions taken: Running counts of medications are put into place to identify and address any shortfall.

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

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