Unannounced Medicines Management Inspection Report
18 September 2017

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 care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Burnview Healthcare Ltd **Responsible Individual:** Mrs Briege Agnes Kelly	**Registered Manager:** Mrs Ciara Power
Person in charge at the time of inspection: Mrs Ciara Power	**Date manager registered:** 31 March 2014
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 Residential Home (RC) I – old age not falling within any other category	**Number of registered places:** 34 comprising not more than two residential beds, not more than two patients in category NH-MP and a maximum of eight persons in category NH-PH.

4.0 Inspection summary

An unannounced inspection took place on 18 September 2017 from 10.40 to 15.10.

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.

The inspection assessed progress with any areas for improvement identified since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to medicines administration, medicine records, storage and the management of controlled drugs.

There were no areas for improvement identified.

Relatives said that their relatives “were very well cared for”.

The term ‘patients’ is used to describe those living in Rockfield Care Home which provides both nursing and residential care.

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	0	0

This inspection resulted in no areas for improvement being identified. 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.

4.2 Action/enforcement taken following the most recent premises inspection

Other than the action detailed in the QIP no further actions were required to be taken following the most recent inspection on 27 June 2017.

Enforcement action did not result 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 records:

- 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

During the inspection the inspector met with two relatives, three registered nurses, the registered manager and the registered person.

A total of 15 questionnaires were provided for distribution to patients, their representatives and staff for completion and return to RQIA.

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
- medicines storage temperatures
- controlled drug record book

Areas for improvements identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

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 27 June 2017

The most recent inspection of the home was an announced premises inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at the next premises inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 22 September 2016

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

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Medicines were managed by staff who have been trained and deemed competent to do so. Registered nurses had attended training which was provided by the community pharmacist within the last year. An induction process was in place for registered nurses and for care staff who had been delegated medicine related tasks. Training was discussed with two recently recruited registered nurses; both were complimentary regarding the training and support which they had received. The impact of training was monitored through the home's auditing systems. Training on the management of medicines and nutrition via the enteral route was planned for 19 September 2017.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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. This safe practice was acknowledged.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

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. warfarin and insulin. The use of separate administration charts was acknowledged.

Appropriate arrangements were in place for administering medicines in disguised form.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. It was agreed that registered nurses would record that the controlled drugs were being denatured.

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. Staff were reminded that prophylactic liquid antibiotics must be disposed of at their expiry. Medicine refrigerators and oxygen equipment were checked at regular intervals.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and controlled drugs.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

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. Care plans were in place. 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 registered nurse advised that the reason for and the outcome of any administration of these medicines would be recorded on the reverse of the administration records and in the daily progress notes; there had been no recent administrations.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place. 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. Staff also advised that a pain assessment is 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. Care plans and speech and language assessments were in place. Records of administration were in place; these included the prescribed consistency level.

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. There was evidence that liquid medicines had been requested when patients had been unable to take tablets/capsules.

Medicine records were well maintained and facilitated the audit process. A small number of missing signatures for administration were observed; one of the registered nurses advised that this finding was due to be discussed at the staff training which was planned for the day after the inspection.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for medicines which were not supplied in the blister pack system. 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 are contacted in response to medication related issues.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The administration of medicines to patients was observed to be completed in a caring manner; patients were given time to take their medicines. Pain relief was being offered.

Of the questionnaires that were issued, one was returned from staff within the time period. The response indicated that they were very satisfied with all aspects of the care in relation to the management of medicines.

We spoke to two relatives. Both were complimentary about the care provided in the home.

Their comments included:
"Very well cared for."
"I have no complaints, staff are great."
"Staff are great they go above and beyond."

Patients were observed to be relaxed and comfortable in the foyer of the home. Staff were heard to be kind and courteous.

Areas of good practice

Staff listened to patients and relatives and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Written policies and procedures for the management of medicines were in place. They were not examined at the inspection.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

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 registered nurses, 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 at staff handovers.

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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

9th Floor

Riverside Tower

5 Lanyon Place

BELFAST

BT1 3BT

Tel 028 9051 7500

Email info@rqia.org.uk

Web www.rqia.org.uk

@RQIANews