Unannounced Medicines Management Inspection Report
21 October 2016

Oakmont Lodge Residential Unit

Type of service: Residential Care Home
Address: 267 - 271 Old Belfast Road, Bangor, BT19 1LU
Tel No: 028 9146 5822
Inspector: Frances Gault

1.0 Summary

An unannounced inspection of Oakmont Lodge Residential Unit took place on 21 October 2016 from 11:25 to 13:50.

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 residents. 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. Two areas of improvement were identified in relation to the admission process and the confirmation of medicine doses. Two recommendations were made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure residents were receiving their medicines as prescribed. Two areas of improvement were identified in relation to record keeping and a requirement and recommendation 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 residents. Residents consulted with confirmed that they were administered their medicines appropriately. Several residents were looking after their prescribed medicines. These procedures were risk assessed. There were no areas of improvement identified.

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 medicine audit activity. There were no areas of improvement identified.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Vigi Varghese, Senior Care Assistant, as part of the inspection process and with Mrs Lisa Harrison, Registered Manager by telephone after the inspection. 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 care and premises

The most recent inspections to the home were the pre-registration inspections undertaken by the care and estates inspectors on 27 July 2016. Other than those actions detailed in the premises inspection QIP there were no further actions required to be taken following these inspections.

2.0 Service details

Registered organisation/registered person: Maria Mallaband (9) Limited/ Mrs Victoria Craddock	**Registered manager:** Mrs Lisa Harrison
Person in charge of the home at the time of inspection: Mrs Vigi Varghese, Senior Care Assistant	**Date manager registered:** 26 August 2016
Categories of care: **RC-I**	**Number of registered places:** 27

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home

Prior to the inspection, it was ascertained that no incidents involving medicines had been reported to RQIA.

We met with seven residents, including one who had returned to the home to collect some medicines which had been overlooked on discharge.

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 27 July 2016

The most recent inspections of the home were the pre-registration care and premises inspections. No care QIP was issued. The completed premises QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at the next premises inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection

This was the first medicines management inspection to the home.

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. The staff member on duty advised of the training received in relation to the management of medicines.

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 in place to ensure the safe management of medicines during a resident's admission to the home. However, the evidence of this was not always in place. It was recommended that written confirmation should be obtained of all prescribed medicines on admission.

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.

Arrangements were observed for the management of high risk medicines e.g. warfarin. It was noted that though it was the expected practice that changes in warfarin dosage were notified to the staff in writing this had yet to be received after a recent change. There was also no reference to the verbal communication received from the general practitioner in the resident's daily notes. All verbal communication from health care professionals should be documented. A recommendation was made. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately.

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. The temperature of the medicine refrigerator was checked each day.

Areas for improvement

Written confirmation should be obtained of all prescribed medicines on admission. A recommendation was made.

All verbal communication from healthcare professionals should be documented in the resident's daily notes. A recommendation was made.

Number of requirements	0	**Number of recommendations**	2

4.4 Is care effective?

The sample of medicines examined had been administered in accordance with the prescriber's instructions.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the resident's health were reported to the prescriber.

Improvement is required in the completion of the medicine records:

- The personal medication records should be completed by two members of staff with both signing the entries.

- The prescribed dose should be clearly stated on the personal medication records and the medicine administration records (MARs). In one instance the dose was written as "reducing dose" but there was no evidence that confirmation had been received of what dose was to be administered. It was agreed that the staff would confirm the dose with the general practitioner after the inspection. The registered manager later confirmed that this had been done.

- A record of the receipt of all medicines must be maintained. There was little evidence that this was routine practice in the home.

- A record of the return of medicines to the community pharmacist for disposal was in place but there was no record kept of the return of medicines to residents on discharge.

A requirement was made in relation to record keeping.

In order to ensure that all information on the records is accurate, the information on the personal medication records and MARS should be verified at the start of the new medicine cycle to assure the staff that they correlate. It was noted that the details of three currently prescribed medicines were not on the MARs. The administration was being documented on the stock balance sheets. A recommendation was made.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for solid dosage medicines. The action points from the registered manager's audits are displayed in the treatment room.

Areas for improvement

All medicine records must be accurate. A requirement was made.

Management should ensure that there is a process in place to confirm that the details on the personal medication records correlates with those on the MARs. A recommendation was made.

Number of requirements	1	Number of recommendations	1

4.5 Is care compassionate?

Several of the residents were looking after their prescribed medicines as they enjoyed a period of respite care in the home. The management of this was discussed. Risk assessments were in place which are reviewed each week. This good practice was acknowledged.

The administration of medicines was not observed during the inspection.

The residents spoken with during the inspection were complimentary of the care and surroundings.

One said "this is my hotel holiday this year" while another advised things were "100%".

Lunch was being enjoyed in the dining room. A choice was available which looked and smelt appetising.

One resident commented on the quality of lightning in their bedroom and this was brought to the attention of the staff for action.

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. It was acknowledged that the home had recently opened and the procedures had to be embedded into practice.

Staff confirmed that they knew how to identify and report any medicine related incidents.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to the management of medicines.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Vigi Varaghese, Senior Care Assistant, as part of the inspection process and with the registered manager by telephone after the inspection. 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 residential care 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 Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011). 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 RQIA's office 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

Statutory requirements

Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 30 November 2016	The registered provider must ensure that all medicine records are in place and accurately maintained. **Response by registered provider detailing the actions taken:** A full audit has been completed and it can be confirmed that all medicine records are in place and accurately maintained.

Recommendations

Recommendation 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that written confirmation is obtained of all prescribed medicines on admission. **Response by registered provider detailing the actions taken:** This continues to be requested from the GP prior to admission.
Recommendation 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that all verbal communication from healthcare professionals is documented in the resident's daily notes. **Response by registered provider detailing the actions taken:** The Warfarin doseage is now being recorded in the daily notes as well as the warfarin administration record.

Recommendation 3 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 30 November 2016	The registered provider should ensure that there is a process in place to confirm that the details on the personal medication records correlates with those on the MARs sheets. **Response by registered provider detailing the actions taken:** This is completed by the SCA on duty and they are now asking the next SCA on duty to verify and double sign all entries.

Name of registered manager/person completing QIP	Lisa Harrison		
Signature of registered manager/person completing QIP	[signature]	**Date completed**	15.11.16.
Name of registered provider approving QIP	VICTORIA CRADDOCK		
Signature of registered provider approving QIP	[signature]	**Date approved**	21/11/16
Name of RQIA inspector assessing response	FRANCES GANLY		
Signature of RQIA inspector assessing response	[signature]	**Date approved**	9/12/16

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