# Unannounced Medicines Management Inspection Report
# 26 September 2017

# 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: 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 residential care home with 27 beds that provides care for residents over 65 years of age.

## 3.0 Service details

| | |
|---|---|
| **Registered Organisation:**<br>Maria Mallaband (9) Limited<br><br>**Responsible Individual:**<br>Mrs Victoria Craddock | **Registered Manager:**<br>Mrs Lisa Harrison |
| **Person in charge at the time of inspection:**<br>Mrs Lisa Harrison | **Date manager registered:**<br>26 August 2016 |
| **Categories of care:**<br>Residential Care (RC)<br>I – old age not falling within any other category | **Number of registered places:**<br>27 |

## 4.0 Inspection summary

An unannounced inspection took place on 26 September 2017 from 10.15 to 14.50.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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).

The inspection assessed progress with any areas for improvement identified during and 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, the maintenance of the majority of medicine records, storage and the management of controlled drugs.

Areas requiring improvement were identified in relation to the confirmation of medicines on admission and the standard of maintenance of the personal medication records.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents' experience.

## 4.1 Inspection outcome

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 0 | *2 |

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Lisa Harrison, Registered Manager, 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.

## 4.2 Action/enforcement taken following the most recent care inspection

No further actions were required to be taken following the most recent inspection on 23 May 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 home was reviewed. This included the following:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medication related incidents

During the inspection the inspector met with three residents, two members of staff and the registered manager.

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

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

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

Areas for improvement 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 23 May 2017

The most recent inspection of the home was an unannounced care inspection. There were no areas for improvement made as a result of the inspection.

## 6.2 Review of areas for improvement from the last medicines management inspection dated 21 October 2016

| Areas for improvement from the last medicines management inspection | | |
|---|---|---|
| **Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005** | | **Validation of compliance** |
| **Area for improvement 1**<br><br>**Ref:** Regulation 13 (4)<br><br>**Stated:** First time | The registered provider must ensure that all medicine records are in place and accurately maintained. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The four areas identified for improvement at the last medicines management inspection had been addressed and hence this area for improvement was assessed as met.<br><br>Some improvements in the standard of maintenance of the personal medication records were necessary as detailed in Sections 6.4 and 6.5. | |
| **Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)** | | **Validation of compliance** |
| **Area for improvement 1**<br><br>**Ref:** Standard 30<br><br>**Stated:** First time | The registered provider should ensure that written confirmation is obtained of all prescribed medicines on admission. | **Not met** |
| | **Action taken as confirmed during the inspection**:<br>Although this is the expected practice written confirmation of currently prescribed medicines was not in place for two recent admissions.<br><br>This area for improvement was stated for the second time. | |

| | | |
|---|---|---|
| **Area for improvement 2**<br><br>**Ref:** Standard 30<br><br>**Stated:** First time | The registered provider should ensure that all verbal communication from healthcare professionals is documented in the resident's daily notes. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>There was evidence that verbal communication from healthcare professionals was documented in the resident's notes. | |
| **Area for improvement 3**<br><br>**Ref:** Standard 31<br><br>**Stated:** First time | 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. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The registered manager advised that the personal medication records were checked each month to ensure correlation with the medication administration records. However, some non-correlation was observed as the personal medication records had not always been updated in a timely manner.<br><br>This area for improvement as written has been assessed as met; however, an area for improvement regarding the standard of maintenance of the personal medication records was identified as detailed in Sections 6.4 and 6.5. | |

## 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.**

The registered manager confirmed that medicines were managed by staff who have been trained and deemed competent to do so. Senior carers had attended training provided by the community pharmacist in November 2016. Update training was completed annually via e-learning. Competency assessments were also completed annually. The impact of training was monitored through the home's audit processes and annual personal learning and development plans.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. However, it was noted that seven doses of a nutritional supplement had recently been omitted due to non-availability. The registered manager had been made aware. This was discussed in detail and the registered manager was reminded that non-administration due to stock issues should be referred to the prescriber and reported as a medication incident. Due to the assurances provided an area for improvement was not made.

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 mostly satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two members of staff. However, some updates had not been recorded on the personal medication records; this area for improvement was incorporated into the area for improvement regarding the standard of maintenance of the personal medication records as detailed in Section 6.5.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been provided by the Trust.

Whilst procedures were generally in place to ensure the safe management of medicines during a resident's admission to the home and discharge from the home, written confirmation of currently prescribed medicines had not been provided for two recently admitted residents. An area for improvement was identified for the second time.

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.

Mostly satisfactory arrangements were observed for the management of warfarin. Dosage directions were received in writing. Records of administration and running balances were recorded twice, it was agreed that this process would be streamlined. It was also agreed that obsolete dosage directions would be cancelled and archived.

Discontinued or expired medicines were returned to the community pharmacy for 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. The consistent recordings for the maximum and minimum temperatures of the refrigerator suggested that the thermometer was not being reset each day. Guidance on resetting the thermometer was provided for the senior carer and registered manager. The registered manager advised that all senior carers would receive supervision on resetting the thermometer.

**Areas of good practice**

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

**Areas for improvement**

No new areas for improvement were identified. However, one area for improvement under Standard 30 has been stated for a second time in relation to obtaining written confirmation of currently prescribed medicines on admission to the home.

| | 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 and twice weekly medicines were due.

A small number of residents were 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 and detailed protocols for their use were in place. Staff advised that the residents were able to request these medicines when necessary. The reason for the administration was recorded on most occasions. It was agreed that the outcome would also be recorded.

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 resident was comfortable. Staff advised that all residents could verbalise any pain. Protocols for the management of pain 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 residents' health were reported to the prescriber.

The majority of medicine records were maintained in a satisfactory manner. However, the following improvements are necessary on the personal medication records:

- the date of writing should be recorded
- the date of prescribing of each medicine should be recorded
- all currently prescribed medicines should be recorded

An area for improvement was identified.

It was agreed that the layout of the medicines file would be reviewed to ensure that the personal medication records and medication records would be filed beside each other. Supplementary records, including "when required" protocols and running balances sheets should then be filed after these records.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for medicines not supplied in the blister pack system. 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 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**

The registered person shall ensure that the personal medication records are fully and accurately maintained.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 0 | 1 |

**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.**

Appropriate arrangements were in place to facilitate residents responsible for the self-administration of medicines. These medicines were audited weekly and hence there was a clear audit trail to evidence handover and compliance. It was agreed that a record of the transfer of the medicines to the residents would be maintained.

We observed the lunchtime medication round. The administration of medicines to residents was completed in a caring manner; residents were given time to take their medicines and medicines were administered as discreetly as possible.

Of the questionnaires that were issued, four were returned from residents and one was returned from a relative. The responses indicated that they were very satisfied/satisfied with all aspects of the care in relation to the management of medicines.

Residents advised that they were “very happy” in the home and that they “could ask for anything.”

**Areas of good practice**

Staff listened to residents 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. Management advised that these were reviewed regularly. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them. .

The management of incidents was discussed in detail with the registered manager and senior carer especially with regards to the management of missed doses due to supply issues. They were aware that 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 care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Not all of the areas for improvement identified at the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement sustained, it was suggested that the report and QIP should be regularly reviewed as part of the quality improvement process.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff at handovers and team meetings.

**Areas of good practice**

There were examples of good practice in relation to governance arrangements. 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

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Lisa Harrison, Registered Manager, 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 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.

## 7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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).

## 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 QIP via Web Portal for assessment by the inspector.

## Quality Improvement Plan

| Action required to ensure compliance the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011) | |
|---|---|
| **Area for improvement 1**<br><br>**Ref:** Standard 30<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>26 October 2017 | The registered provider should ensure that written confirmation is obtained of all prescribed medicines on admission.<br><br>Ref: 6.2 and 6.4 |
| | **Response by registered person detailing the actions taken:**<br>This has been discussed with all Senior Care staff and a recent audit identified that this is now in place. This will be monitored ongoing as part of the auditing process. |
| **Area for improvement 2**<br><br>**Ref:** Standard 31<br><br>**Stated:** First time<br><br>**To be completed by:**<br>26 October 2017 | The registered person shall ensure that the personal medication records are fully and accurately maintained.<br><br>Ref: 6.4 and 6.5 |
| | **Response by registered person detailing the actions taken:**<br>All personal medication records have been audited and are now up to date. The importance of this has been reiterated to Senior Care staff and is being prioritised. Some amendments have also been made to the personal medication record to facilitate these improvements. |

***Please ensure this document is completed in full and returned via web portal***

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