Announced Medicines Management Inspection Report
10 March 2017

Strand House – Bohill Bungalows

Type of service: Residential Care Home
Address: 69 Cloyfin Road, Coleraine, BT52 2NY
Tel no: 028 7032 5180
Inspector: Frances Gault

1.0 Summary

An announced inspection of Strand House – Bohill Bungalows took place on 10 March 2017 from 10.20 to 12.40.

This was the post registration inspection in relation to medicines management in this newly registered residential care home. Previously this home was registered as a nursing home. The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

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).

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. Robust systems had been put 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 robust systems in place to ensure residents 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 residents. Residents welcomed us into their home and chatted about their plans for the day. They 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 medicine audit activity. No requirements or recommendations were made.

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 Ms Lorna King, 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 18 October 2016.

2.0 Service details

Registered organisation/registered person: Parkcare Homes No2 Ltd Mrs Sarah Hughes	**Registered manager:** Ms Lorna King
Person in charge of the home at the time of inspection: Ms Lorna King	**Date manager registered:** 17 January 2017
Categories of care: RC-LD, RC-LD(E)	**Number of registered places:** 6

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the incidents register – it was ascertained that no incidents involving medicines had been reported to RQIA

We met with three residents, two care staff, the registered manager and the registered manager from the adjoining bungalows.

Fourteen questionnaires were issued to residents, relatives/representatives and staff, with a request that they were returned within one week from the date of 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
- care plans
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 18 October 2016

The most recent inspection of the home was the pre-registration care inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the care inspector at the next care inspection.

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

This was the first medicines management inspection to the home since it was registered as a residential care home.

4.3 Inspection findings

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 care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings and supervision. Competency assessments were completed annually. Senior care staff have been trained and deemed competent in the administration of insulin. The most recent training was in relation to the management of insulin.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage.

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 members of staff. This safe practice was acknowledged.

Robust arrangements were observed for the management of insulin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were returned to the community pharmacist for disposal.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. The medicine storage area was 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 medicine refrigerator was checked at regular intervals.

Is care effective?

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

When a resident was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, specific 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 resident's behaviour and were aware that this change may be associated with pain and there was evidence that pain relief was administered when this occurred. A "when required" protocol was included on the medicine folder. These medicines had not been administered in recent weeks. The staff advised that the administration of these medicines was reviewed monthly within the home.

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 the residents could verbalise any pain, and pain assessment tools were in place. One resident advised that she had requested and been administered something for pain the previous evening. This had been documented appropriately in the records.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included, evidence that two staff had checked the MARs records prior to the commencement of the new medicine cycle and the use of the reverse of the administration records to record the rationale for, and effect of the administration of "when required" medicines. Care staff maintain administration records for the use of external preparations. However, on occasion, when medicines had been obtained during the medicine cycle, it was noted that staff had forgotten to record the date of receipt. It was agreed with the registered manager that staff would be reminded of the correct procedure.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for medicines not contained in the monitored dosage 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 the health needs of the residents.

Is care compassionate?

We were welcomed into the home by a resident who examined our identification. It was pleasing to see that staff had prepared the residents for our visit and three of them engaged with us during the inspection. One resident was able to advise that while she couldn't look after her own medicines, she knew what they were and their purpose.

One resident told us that the manager was "brilliant" while others advised how they would be spending their day. Some residents were going out to an activity, while another resident decided she would like a walk and this was being facilitated.

All of the residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Staff advised that medicines were administered in accordance with the resident's preferences.

As part of the inspection process, we issued questionnaires to residents, residents' representatives and staff. None of these had been returned within the time frame but any

comments will be followed up with the manager and included in the next medicine management report.

Is the service well led?

Written policies and procedures for the management of medicines were in place. These had been examined as part of the registration procedures.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. When discrepancies are noted the registered manager advised that the learning is shared with the staff.

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.

Staff confirmed that any concerns in relation to medicines management were raised with management.

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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