Unannounced Post-Registration Medicines Management Inspection Report
9 April 2018

Three Rivers Residential Care Home

Type of service: Residential Care Home
Address: 11 Millbank Lane, Omagh, BT79 7YD
Tel No: 028 8225 8227
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 provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Three Rivers Residential Care Home is situated on the same site as Three Rivers Care Centre. It is a residential care home with 25 beds that provides care for residents who are living with dementia.

3.0 Service details

Organisation/Registered Provider: Zest Care Homes Limited **Responsible Individual(s):** Mr Philip Scott	**Registered Manager:** Mrs Marie Bridget Armstrong
Person in charge at the time of inspection: Ms Emily Jefferson (Senior Carer)	**Date manager registered:** 18 December 2017
Categories of care: Residential Care (RC): DE – dementia	**Number of registered places:** 25

4.0 Inspection summary

An unannounced inspection took place on 9 April 2018 from 10.30 to 13.40.

This was the post registration inspection in relation to medicines management in this newly registered residential care home, located within Three Rivers Care Centre. 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 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).

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

Areas requiring improvement were identified in relation to updates on the medication administration records and care plans relating to distressed reactions.

Residents appeared relaxed and comfortable. They were complimentary regarding the staff and care provided in the home.

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

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Emily Jefferson, Senior Carer, and Mrs Marie Bridget Armstrong, Registered Manager, by telephone call on 20 April 2018, 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 pre-registration care inspection

No further actions were required to be taken following the most recent inspection on 28 March 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
- recent correspondence with the home
- the management of incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the home was registered

During the inspection the inspector met with two residents, one placement student, one care assistant, the senior carer and the registered manager of Three Rivers Care Centre.

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

A total of 10 questionnaires were provided for distribution to residents 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
- controlled drug record book
- medicine audits
- care plans
- training records
- medicines storage temperatures

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 pre-registration care inspection dated 28 March 2017

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

This was the first medicines management inspection to the home.

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. Training was completed via e-learning annually. In addition face-to-face training had been provided by the community pharmacist in February 2018. The impact of training was monitored through the audit process. The registered manager confirmed (via telephone call) that competency assessments were completed following induction and annually thereafter.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed within the last year.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available. Antibiotics and newly prescribed medicines had been received into the home without delay.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and discharge from the home.

There were mostly satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. However, several hand-written entries on the medication administration records had not been verified and signed by two members of staff. This should occur to ensure safe systems for medicines administration. An area for improvement was identified.

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.

The registered manager and senior carer were reminded that discontinued or expired medicines should be returned to the community pharmacy for disposal and that controlled drugs should not be denatured prior to 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 maximum, minimum and current refrigerator temperatures were monitored daily. Satisfactory temperature recordings were observed.

Two oxygen cylinders were observed in the treatment room. One, which was prescribed for a resident who was no longer in the home, was removed for return to the community pharmacy. The second cylinder had been prescribed recently for use as needed but had never been used. It was agreed that this would be reviewed with the prescriber and that training would be arranged for staff if necessary.

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

Hand-written entries on the medication administration records should be verified and signed by two members of staff.

	Regulations	Standards
Total number of areas for improvement	0	1

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 were arrangements in place to alert staff of when doses of twice weekly medicines were due.

When a resident 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. 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. The reason for and the outcome of administration were recorded. However, detailed care plans directing the use of these medicines were not in place for all designated residents. An area for improvement was identified. For one resident, regular administration was observed. The senior carer advised that the prescriber would be contacted for a review.

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 resident was comfortable. The registered manager confirmed that all residents could verbalise their pain. The reason for and outcome of administration of 'when required' analgesia was recorded. This good practice was commended.

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

Medicine records were well maintained and facilitated the audit process. A small number of obsolete personal medication records had not been cancelled and archived. The senior carer addressed this issue during the inspection. As detailed in Section 6.4, hand-written updates on the medication administration records should be verified and signed by two members of staff.

Practices for the management of medicines were audited throughout the month by staff and management. This included running stock balances for nutritional supplements, daily, weekly and monthly audits.

Following discussion with the registered manager and the senior carer, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in resident care.

Areas of good practice

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

Areas for improvement

Detailed care plans should be in place for the management of distressed reactions.

	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.

We observed the administration of medicines after lunch. The senior carer administered the medicines in a caring manner, taking time to ensure that residents were happy to take their medicines. The senior carer was knowledgeable about each resident's medicines and guidance was displayed on the medicines file for easy reference.

Throughout the inspection, it was found that there were good relationships between the staff and the residents. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was clear from discussion and observation of staff, that the staff were familiar with the residents' likes and dislikes.

The residents spoken to at the inspection advised that they were happy in the home and that staff were "kind".

Residents were observed to be relaxed and comfortable.

As part of the inspection process, we issued ten questionnaires to residents and their representatives, none were returned within the specified timeframe.

Areas of good practice

Staff listened to residents 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

The inspector discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents. Arrangements were in place to implement the collection of equality data within Three Rivers Residential Care Home.

Written policies and procedures for the management of medicines were in place. They were not examined. It was agreed that the policy for the disposal of medicines would be reviewed and revised.

The senior carer advised that there were robust arrangements in place for the management of medicine related incidents. In relation to the regional safeguarding procedures, staff were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the daily, weekly and monthly audit records indicated that largely satisfactory outcomes had been achieved.

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

The senior carer and care assistant confirmed that any concerns in relation to medicines management were raised with management. They advised that management were open and approachable and willing to listen.

Areas of good practice

There were examples of good practice in relation to governance arrangements 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

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Emily Jefferson, Senior Carer, and Mrs Marie Bridget Armstrong, 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 with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)

Area for improvement 1 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 9 May 2018	The registered person shall ensure that hand-written entries on the medication administration records are verified and signed by two members of staff. Ref: 6.4
	Response by registered person detailing the actions taken: The hand written entries on the MARS sheets have been discussed with the pharmacist and wherever possible, when a new medication is commenced or there are direction changes a pharmacy printed MARS will be sent to us same day. In the event that a printed MARS cannot be made available and there is no choice other than to make a hand written entry the Senior Carers have been instructed that all entries must have 2 witnessing signatures and that that a Carer can be witness to the entry. Compliance with the above will be audited on a weekly as part of routine medication audits.
Area for improvement 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 9 May 2018	The registered person shall ensure that detailed care plans are in place for the management of distressed reactions. Ref: 6.5
	Response by registered person detailing the actions taken: The Managemer and Senior Carers are currently updating and reviewing all care plans to ensure protocols are in place concerning administration of medication relating to distressed reactions. These will include the nature of the distressed reaction, the indications for administration of the prescribed medication and any effect of same in alleviating the distressed reaction.

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

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