Unannounced Post-Registration Medicines Management Inspection Report
21 September 2018

Edgewater Lodge

Type of service: Residential Care Home
Address: Seaview Suite, 4 Sunnydale Avenue, Donaghadee, BT21 0LE
Tel No: 028 9188 8044
Inspector: Catherine Glover

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

This is a residential care home with 17 beds that provides care for residents living with dementia. The residential care home is on the same site as Edgewater nursing home.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care Responsible Individual: Dr Maureen Claire Royston	Registered Manager: Mrs Vera Ribeiro
Person in charge at the time of inspection: Ms Vera Nikolajeva, Senior Care Assistant	**Date manager registered:** 12 February 2018
Categories of care: Residential Care (RC) DE – Dementia	**Number of registered places:** 17

4.0 Inspection summary

An unannounced inspection took place on 21 September 2018 from 10.10 to 13.00.

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).

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).

The inspection assessed progress with any areas for improvement identified since the pre-registration care 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 care planning, medicine records and the storage of medicines.

Areas for improvement were identified in relation to the training and competency of senior care assistants, administration of analgesic patches, the administration of inhaled medicines and records relating to the administration of "when required" anxiolytics.

Residents were comfortable in the home and good relationships with staff were noted.

The findings of this report will provide the management of 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	4

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Vera Ribeiro, 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 pre-registration inspection

No further actions were required to be taken following the most recent inspection on 5 January 2018. 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:

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

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

During the inspection we met with two residents and one senior care assistant. We met with the registered manager for feedback at the end of the inspection.

We provided the senior care assistant with ten questionnaires to distribute to residents and their representatives, for completion and return to RQIA. 'Have we missed you?' cards were left in the foyer of the home to inform residents/their representatives of how to contact RQIA, to tell us of their experience of the quality of care provided. Flyers providing details of how to raise any concerns were also left in the home.

We asked the senior care assistant to display a poster which invited staff to share their views and opinions 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
- medicines disposed of or transferred
- 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 most recent inspection dated 5 January 2018

The most recent inspection of the home was an announced 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

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.

Records of training and competency were provided for inspection. It was observed that training in the management of medicines had been completed in 2017 prior to the home registering with RQIA. There was no evidence of senior care assistants completing training in the new medicine system that had been recently introduced. The registered manager advised that training was provided by e-learning, however this had not been completed by any of the staff that were responsible for the management of medicines. Records of competency had not been updated since April 2017. An area for improvement was identified.

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

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 to identify and report any potential shortfalls in medicines. 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 were updated by two members of staff. This safe practice was acknowledged.

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.

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 medicine refrigerator and oxygen equipment were checked at regular intervals.

Areas of good practice

There were examples of good practice found in relation to the management of medicines on admission and the storage of medicines.

Areas for improvement

The registered person shall ensure that staff training and competency assessment is regularly completed and records are maintained.

	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 majority of medicines examined had been administered in accordance with the prescriber's instructions. Discrepancies were noted in the administration of inhaled medicines. These medicines must be closely monitored to ensure that they are being administered as prescribed. An area for improvement was identified.

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. A care plan was maintained. The reason for and the outcome of administration had not been recorded. This information should be recorded when these medicines are administered. An area for improvement was identified.

The sample of records examined indicated that medicines which were prescribed to manage pain had not always 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. However, it was noted that on four occasions in previous months, analgesic patches which are prescribed to be administered at weekly intervals had been administered several days late. Additional records to record the site of these patches had not been fully completed and the controlled drugs reconciliation checks had also not highlighted the omission of these medicines. These patches must be closely monitored to ensure that they are administered at the correct dosage intervals. An area for improvement was identified.

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

Medicine records were generally well maintained and facilitated the audit process.

Following discussion with staff and a review of several care plans, 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 the residents' care.

Areas of good practice

There were examples of good practice found in relation to the majority of medicine records and care planning.

Areas for improvement

The administration of inhaled medicines and controlled drugs patches must be monitored to ensure that they are administered as prescribed.

The reason for and outcome of administering medicines that are prescribed on a "when required" basis for the management of distressed reactions shall be recorded.

	Regulations	Standards
Total number of areas for improvement	0	3

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 residents was not observed during this inspection, however staff were knowledgeable about the residents' medicines and medical requirements.

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.

We spoke with two residents. They were relaxed and comfortable in the home and said that the staff were good.

None of the questionnaires that were issued for completion by patients and their representatives were returned within the specified time frame for inclusion in this report (two weeks). Any comments from residents and their representatives in questionnaires received after the return date (two weeks) will be shared with the registered manager for information and action as required.

Areas of good practice

There was evidence that 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

Written policies and procedures for the management of medicines were in place. They were not reviewed during this inspection.

There were arrangements in place for the management of medicine related incidents. The registered manager was advised to confirm that the incidents relating to the late administration of patches had been appropriately reported. 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 lead and safeguarding team.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, an action plan to address the issues had been completed. Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for all tablets and capsules, however it was noted that some of these running balances were incorrect and this was discussed with the registered manager. A quarterly audit was also completed by the community pharmacist. The audits had not identified the delayed administrations.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for all tablets and capsules, however it was noted that some of these running balances were incorrect indicating that registered nurses were not actually counting the tablets/capsules. A review of the other audit records indicated that satisfactory outcomes were routinely achieved. Where a discrepancy had been identified, an action plan to address the issues had been completed. These audits had not identified the issues seen at this inspection i.e. poor audit outcomes for inhaled medicines and incomplete training records. The registered manager was advised that the auditing system should be robust in order to identify and address all shortfalls in the management and administration of medicines. Due to the assurances provided an area for improvement was not specified at this time. A quarterly audit was also completed by the community pharmacist.

Staff advised that any concerns in relation to medicines management were raised with management. They advised that the manager and nurses in the adjoining nursing home were available for advice on issues that arose. Staff were also aware that any nursing care should be provided by the community nursing team.

There were no responses to the online staff survey.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to team work. 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 Vera Ribeiro, 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 30 **Stated:** First time **To be completed by:** 21 October 2018	The registered person shall ensure that staff training and competency assessment is regularly completed and records are maintained. Ref: 6.4
	Response by registered person detailing the actions taken: Competency assessments and records are now all up to date.
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 21 October 2018	The registered person shall ensure that the administration of inhaled medicines is monitored to ensure that they are administered as prescribed. Ref: 6.5
	Response by registered person detailing the actions taken: Monitoring of inhaled medicines is carried out by the person in charge of the unit on a daily basis. Registered person spot checks these on a weekly basis
Area for improvement 3 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 21 October 2018	The registered person shall ensure that the administration of controlled drugs patches is monitored to ensure that they are administered as prescribed. Ref: 6.5
	Response by registered person detailing the actions taken: Administration of controlled drugs patches is monitored on a weekly basis by registered person or person in charge.
Area for improvement 4 **Ref**: Standard 8 **Stated:** First time **To be completed by:** 21 October 2018	The registered person shall ensure that the reason for and outcome of administering medicines that are prescribed on a “when required” basis for the management of distressed reactions is recorded. Ref: 6.5
	Response by registered person detailing the actions taken: Reviewed residents with drugs prescribed in case of distressed reactions and discussed these findings with staff. Staff have been advised to record clearly the reason for administration of these drugs and ensure care plans are kept up to date to reflect the reasons for administration.

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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care