# Unannounced Post-Registration Medicines Management Inspection Report
# 5 April 2018

# Lecale Lodge

**Type of Service: Residential Care Home**
**Address: 26 Strangford Road, Downpatrick, BT30 6SL**
**Tel No: 028 4461 6487**
**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

This is a residential care home with 15 beds that provides care for residents with a range of care needs as detailed in Section 3.0.

## 3.0 Service details

| | |
|---|---|
| **Organisation/Registered Provider:**<br>Four Seasons Health Care<br><br>**Responsible Individual:**<br>Dr Maureen Claire Royston | **Registered Manager:**<br>Ms Diana Ashton |
| **Person in charge at the time of inspection:**<br>Ms Diana Ashton | **Date manager registered:**<br>21 February 2018 |
| **Categories of care:**<br>Residential Care (RC):<br>I – old age not falling within any other category<br>MP – mental disorder excluding learning disability or dementia<br>MP(E) - mental disorder excluding learning disability or dementia – over 65 years | **Number of registered places:**<br>15 comprising a maximum of 11 residents in category RC-MP/MP(E) and a maximum of four residents in category RC-I. |

## 4.0 Inspection summary

An unannounced inspection took place on 5 April 2018 from 10.30 to 13.45.

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 medicines administration, medicine records, medicine storage and the management of controlled drugs.

One area requiring improvement was identified in relation to the management of distressed reactions.

We spoke with one resident who was complimentary regarding the care and staff 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 | 1 |

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Diana Aston, 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 care inspection

No further actions were required to be taken following the most recent inspection on 18 December 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 service 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 registered.

During the inspection the inspector met with one resident, two care assistants, the activity therapist, a senior carer and the registered manager.

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 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
- 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 18 December 2017

The most recent inspection of the home was an announced pre-registration 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.**

Medicines were managed by staff who have been trained and deemed competent to do so. Training was completed via e-learning annually. Competency assessments were also completed annually. Records were provided for inspection. The registered manager had provided training on mental health conditions in March 2018.

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.

The registered manager and senior care assistant advised that robust systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available. However, it was noted that two medicines were unavailable for administration on the day of the inspection. There was evidence that this had been followed up with the prescriber. The registered manager advised that this would be closely monitored. Antibiotics and newly prescribed medicines had been received into the home without delay.

The registered manager was currently reviewing the arrangements for the acquisition of prescriptions.

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 satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. Hand-written entries on the medication administration records were also verified and signed by two 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.

The registered manager and senior carer were reminded that discontinued or expired medicines should be returned to the community pharmacist for disposal and that controlled drugs do not need to be denatured prior to disposal in a residential care home.

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 medicine refrigerator temperatures were monitored daily. Satisfactory temperature recordings were observed.

**Areas of good practice**

There were examples of good practice found throughout the inspection in relation to staff training, competency assessments, the management of medicines on admission and controlled drugs.

**Areas for improvement**

No areas for improvement were identified during the inspection.

| | 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 majority of medicines examined had been administered in accordance with the prescriber's instructions. Two discrepancies were highlighted for close monitoring.

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

We reviewed the management of medicines prescribed to be administered "when required" 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. However, detailed care plans directing the use of these medicines were not in place. Systems were in place to record the reason for and outcome of administration; however, these had not been completed on all occasions. The senior care assistant advised that supervisions would be carried out with all staff. An area for improvement was identified.

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.

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. Staff were commended on the standard of maintenance of the personal medication records and medication administration records.

Practices for the management of medicines were audited throughout the month by staff and management. This included running stock balances for all medicines.

Following discussion with the registered manager and staff, 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, care planning and the administration of medicines.

**Areas for improvement**

Detailed care plans should be in place for the management of distressed reactions. The reason for and outcome of administration should be recorded.

| | 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.**

The administration of medicines to residents had been completed prior to the commencement of this inspection and was not observed. Staff were knowledgeable about the administration of 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 resident spoken to at the inspection, advised that they had no concerns in relation to the management of their medicines and they were happy for the staff to administer their medicines.

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As part of the inspection process, we issued 10 questionnaires to residents and their representatives. Seven residents completed and returned the questionnaires. The responses indicated that they were satisfied/ very satisfied with all aspects of the care in relation to the management of medicines.

**Areas of good practice**

Staff were observed to engage with residents and encourage them to take part in activities.

**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 Lecale Lodge.

Written policies and procedures for the management of medicines were in place. These were not examined in detail.

There were robust arrangements in place for the management of medicine related incidents. 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, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the registered manager, senior carer and care assistants, 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 of good practice**

There were examples of good practice found throughout the inspection in relation to governance arrangements, the management of medicine incidents 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 Diana Aston, 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)**

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|---|---|
| **Area for improvement 1**<br><br>**Ref**: Standard 6<br><br>**Stated:** First time<br><br>**To be completed by:**<br>5 May 2018 | The registered person shall review and revise the management of distressed reactions as detailed in the report.<br><br>Ref: 6.4 |
| | **Response by registered person detailing the actions taken:**<br>Senior care staff have now had clinical supervision sessions,to highlight the importance of the timely completion of the distressed reaction forms.These sessions also discussed the importance of the need to complete a distressed reaction form even when a resident requests prn medication. |

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

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