Unannounced Post-Registration Medicines Management Inspection Report
21 August 2018

Dunlarg Care Home

Type of service: Residential Care Home
Address: 224 Keady Road, Armagh, BT60 3EW
Tel No: 028 3753 0858
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 eight beds that provides care for older people. The residential care home is on the same site as a nursing home.

3.0 Service details

Organisation/Registered Provider: Four Seasons (Bamford) Ltd **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** Mrs Patricia Graham
Person in charge at the time of inspection: Mrs Aileen Warnock, Senior Care Assistant	**Date manager registered:** 12 February 2018
Categories of care: Residential Care (RC) I – Old age not falling within any other category. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years.	**Number of registered places:** 8

4.0 Inspection summary

An unannounced inspection took place on 21 August 2018 from 10.30 to 12.30.

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 was the first medicines management inspection in this newly registered residential care home situated within Dunlarg Care Home. The inspection was 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 medicine records, care planning, medicine administration, medicine storage and the management of controlled drugs.

No areas for improvement were identified.

There was a welcoming atmosphere in the home and good relationships between staff, residents and visitors were evident.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Edel Treanor, Deputy 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.

4.2 Action/enforcement taken following the pre-registration inspection

The most recent inspection of the home was an announced pre-registration care inspection undertaken on 15 January 2018. Other than those actions detailed in the QIP no further actions were required to be taken. 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 incidents: it was ascertained that no incidents involving medicines had been reported to RQIA since the home registered.

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

During the inspection we met with two residents, the deputy manager and two senior care assistants.

Ten questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA.

We requested the deputy manager to display a poster in the home inviting staff to share their views of the home by completing an online questionnaire.

The inspector left “Have we missed you?” cards. The cards facilitate residents or relatives who were not present at the time of the inspection to give feedback to RQIA on the quality of service provision. Flyers which gave information on raising a concern were also left in the home.

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

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 15 January 2018

The most recent inspection of the home was an announced care inspection. The completed QIP was returned. This QIP will be validated by the care inspector at the next care 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. An induction process was in place for senior care staff who are responsible for medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

There were procedures in place to ensure the safe management of medicines during a patient'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. Antibiotics 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 handwritten entries on medication administration records were updated by two registered nurses. 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.

Robust arrangements were observed for the management of high risk medicines e.g. anticoagulants. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately.

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 was checked at regular intervals.

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 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 medicines were due.

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. A care plan was maintained.

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

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included additional records for recording the site of application of transdermal patches and the reason for and outcome of administering "when required" analgesia was clearly recorded. The quantities of medicines carried over from the previous month was consistently and accurately recorded.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the deputy manager and staff, it was evident that healthcare professionals are contacted when required to meet the needs of residents.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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 regarding the residents' medicines and requirements.

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were noted to be friendly, courteous and happy in their work; they treated the residents with dignity.

We spoke with two residents who told us they were happy in the home and that the staff were "fantastic". They said they had settled well, they liked their rooms and the food was good. One of the residents described the senior care assistant as an "angel" and it was evident they had a good relationship.

Of the questionnaires that were issued, one was returned from a relative. The responses indicated that they were satisfied with the care provided.

Any comments from residents, their representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their 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

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 are place to implement the collection of equality data.

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 staff.

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.

Following discussion with the deputy 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. They advised that management were open, approachable and willing to listen. Staff said that there were good working relationships within the home.

There were no responses to the online staff questionnaire.

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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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