Announced Post-Registration Medicines Management Inspection Report 31 May 2018

Orchard Lodge Care Home

Type of service: Residential Care Home
Address: Desart Lane South, Armagh, BT61 8AR
Tel No: 028 3752 6462
Inspector: Paul Nixon

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 19 beds that provides care for residents living with dementia. It is situated on the ground floor of a building that also includes a nursing home.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Mr Gavin O'Hare-Connolly	**Registered Manager:** Mrs Norma McAllister
Person in charge at the time of inspection: Mrs Norma McAllister	**Date manager registered:** 8 February 2018
Categories of care: Residential Care (RC) DE – Dementia	**Number of registered places:** 19 Residents to be accommodated in the Navan Unit

4.0 Inspection summary

An announced inspection took place on 31 May 2018 from 09.40 to 12.10.

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 determined 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.

No areas requiring improvement were identified.

There was a warm and welcoming atmosphere in the home. Residents were relaxed and good relationships with staff 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 Mrs Norma McAllister, 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.

4.2 Action/enforcement taken following the pre-registration inspection

The most recent inspection of the home was an announced care inspection, undertaken on 11 May 2018. No areas for improvement were identified. 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.

During the inspection the inspector met with the registered manager, the care team leader and one care assistant.

Ten 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 11 May 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 residents 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 registered nurses and for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was provided in the last year.

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 and newly prescribed medicines had been received into the home without delay.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medicine administration records were updated by two members of care staff. This safe practice was acknowledged.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. A safeguarding training update was completed by staff annually.

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

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; however, these checks were not recorded. The registered manager agreed to implement the recording of controlled drug stock checks with immediate effect; given this assurance an area for improvement was not stated.

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

Appropriate arrangements were in place for administering medicines in disguised form.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely. The temperature of the clinical room was 28°C; the temperature should be maintained below 25°C. The registered manager provided evidence that the excessive temperature of this room had been identified and that an air conditioning unit had been ordered and would be installed upon its arrival. 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, the management of controlled drugs and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 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.

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. A care plan was maintained. These medicines had not been recently used.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff advised that a pain assessment was completed as part of the admission process. They were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. 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.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for most medicines not dispensed in

the monitored dosage system blister packs. In addition, a periodic audit was completed by the community pharmacist.

Following discussion with the staff and examination of records, it was evident that other healthcare professionals were contacted, when required, to meet the needs of residents. 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 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?

Residents and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

It was not possible to ascertain the views and opinions of residents; however, they were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were knowledgeable regarding the residents' needs, wishes and preferences. Staff and resident interaction and communication demonstrated that residents were treated courteously, with dignity and respect.

Of the questionnaires that were issued, two were returned from relatives. The responses indicated that they were very satisfied/satisfied with all aspects of the care. One relative commented, "Staff are all great…can't praise them enough."

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 are place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place; these were not examined. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them.

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 satisfactory outcomes had been achieved. The registered manager advised that, if a discrepancy was identified, an action plan would be drawn up, implemented and followed up at the next audit.

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. They stated that there were good working relationships within the home and with healthcare professionals involved in resident care.

No members of staff shared their views by completing an online 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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