Announced Post-Registration Medicines Management Inspection Report
1 May 2018

Ratheane Care Home

Type of service: Residential Care Home
Address: 58 Mountsandel Road, Coleraine, BT52 1JF
Tel No: 028 7034 4299
Inspector: Rachel Lloyd

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 registered to provide care for up to17 persons with a variety of care needs as detailed in section 3.0. The residential care home is on the same site as a nursing home.

3.0 Service details

Organisation/Registered Provider: Macklin Group **Responsible Individuals:** Mr Brian Macklin Mrs Mary Macklin	**Registered Manager:** Mrs Araceli Flores
Person in charge at the time of inspection: Mrs Araceli Flores	**Date manager registered:** 22 September 2017
Categories of care: Residential Care (RC) I – Old age not falling within any other category PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 17

4.0 Inspection summary

An announced inspection took place on 1 May 2018 from 10.00 to 12.50.

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).

This was the first medicines management inspection since registration. The inspection sought 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.

Areas for improvement were identified in relation to the disposal of medicines and policies and procedures for the management of medicines.

The residents spoken to advised that they were satisfied with the management of their medicines and the 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 Mrs Araceli Flores, 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

The most recent inspection of the home was an announced pre-registration care inspection undertaken on 8 September 2017. 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:

- the pre-registration care inspection report and returned QIP
- recent correspondence with the home
- the management of medicine related incidents 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 the inspector met with three residents, one senior care assistant, and the registered manager.

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 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 8 September 2017

The most recent inspection of the home was an announced pre-registration care inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the care inspector at the next care inspection.

6.2 Inspection findings

6.3 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. The impact of training was monitored through team meetings, supervision and appraisal. Competency assessments were completed. Refresher training in medicines management was 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 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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of any prescriptions.

Robust arrangements were in place to manage changes to prescribed medicines. Personal medication records and medicine administration records were routinely 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.

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

Discontinued or expired medicines were disposed of into pharmaceutical clinical waste bins. Because this is a residential care home, medicines should be returned to the community pharmacy for disposal. This should also be reflected in the policy and procedure for the disposal of medicines. An area for improvement was identified.

Medicines were stored safely and securely. However, the temperature of the medicines storage area should be monitored and recorded on a daily basis to ensure that all medicines are stored in accordance with the manufacturer's instructions. This was addressed immediately. 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, the management of medicines on admission, the management of changes to medication and the management of controlled drugs.

Areas for improvement

The disposal of medicines should be reviewed to ensure that discontinued or expired medicines are returned to the community pharmacy for disposal. This should also be reflected in the policy and procedure for the disposal of medicines.

	Regulations	Standards
Total number of areas for improvement	0	1

6.4 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, monthly or three monthly 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. It was acknowledged that these medicines had not been administered recently. A care plan was in place.

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 most of the residents could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment is completed as part of the admission process.

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 readily facilitated the audit process. Staff were commended on the standard of record keeping and areas of good practice were acknowledged. These included the use of separate personal medication records for antibiotics and transdermal patch administration record sheets.

Practices for the management of medicines were audited throughout the month by staff and management. This included maintaining running stock balances for medicines not supplied in the monitored dosage system. In addition, audits were completed by the community pharmacist.

Following discussion with the manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to the needs of the residents.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the standard of record keeping 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

6.5 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 observed briefly and was completed in a caring manner. Residents were given time to take their medicines and medicines were administered as discreetly as possible.

Throughout the inspection, good relationships were observed between the staff and the residents. Staff were noted to be friendly and courteous. Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

The residents spoken to advised that they were satisfied with the management of their medicines and the care provided in the home. Comments made included:

"The girls are very good to me."
"We are well fed here, I'm content."

Ten questionnaires were left in the home to facilitate feedback from residents and relatives. Seven were returned within the specified timescale (two weeks). They all indicated that they were very satisfied with all aspects of the care in relation to the management of medicines. They commented:

"Very good, caring service provided by Yvonne – extremely efficient and kind."
"Very happy."

Any comments from residents, their representatives or staff received after the issue of this report will be shared with the 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

6.6 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. The registered manager confirmed that arrangements were in place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. Following discussion with staff it was evident that they were familiar with these. However, these should be reviewed and revised as necessary, to reflect that this is a residential care home (see also section 6.3). An area for improvement was identified.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. One medicine related incident reported since registration was discussed. There was evidence of the action taken and learning implemented following 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 team.

A review of the audit records indicated that 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 and observation, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with management. They stated that there were good working relationships.

No members of staff shared their views by completing the online questionnaire prior to the issue of this report.

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

Policies and procedures for the management of medicines should be reviewed and revised as necessary, to reflect that this is a residential care home.

	Regulations	Standards
Total number of areas for improvement	0	1

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 Araceli Flores, 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 the 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	The registered person shall ensure that the disposal of medicines is reviewed to ensure that discontinued or expired medicines are returned to the community pharmacy for disposal. Ref: 6.3
To be completed by: 29 May 2018	**Response by registered person detailing the actions taken:** Home Manager has liaised with pharmacist and all medications for disposal will be returned to pharmacy for disposal.
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time	The registered person shall ensure that policies and procedures for the management of medicines are reviewed and revised as necessary, to reflect that this is a residential care home. Ref: 6.6
To be completed by: 29 May 2018	**Response by registered person detailing the actions taken:** Policy and procedures for the management of medicines has been reviewed and revised and reflects that this is a residential home.

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

The Regulation and Quality Improvement Authority

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

Tel 028 9051 7500
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care