Unannounced Post-Registration Medicines Management Inspection Report
14 March 2019

Blair Mayne Residential Care Home

Type of Service: Residential (RC)
Address: c/o Blair House Care Home, 107 Dakota Avenue, Newtownards, BT23 4QX
Tel No: 028 9182 4450
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 that provides care for up to 25 residents with a diagnosis of dementia. The home is in the same building as Blair House Care Home.

3.0 Service details

Organisation/Registered Provider: Amore (Watton) Limited **Responsible Individual:** Mrs Nicola Cooper	**Registered Manager:** Mrs Jacqueline Bowen
Person in charge at the time of inspection: Ms Susan Le Gallez (Deputy Manager)	**Date manager registered:** 29 January 2019
Categories of care: Residential Care (RC) DE – Dementia.	**Number of registered places:** 25 Eleven residents to be accommodated on the ground floor and 14 residents to be accommodated on the first floor.

4.0 Inspection summary

An unannounced inspection took place on 14 March 2019 from 10.40 to 13.30.

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 home was registered 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, storage and the management of controlled drugs.

No areas for improvement were identified.

Residents were relaxed and comfortable in the home. They told us the staff were good and they were happy living there.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Susan Le Gallez (Deputy Manager) and Ms Sharon Butler, Regional Manager, as part of the inspection process and can be found in the main body of the report. One issue regarding staffing was discussed and assurance was provided by the regional manager by email that this had been resolved. This issue was discussed with the care inspector and will be followed up at the next care 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 17 July 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 medicine related incidents.

During the inspection the inspector met with two residents, one resident's relative, the deputy manager, one senior care assistant and one care assistant. The regional manager was present for feedback at the end of the inspection.

We provided the deputy manager 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. 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 17 July 2018

The most recent inspection of the home was an announced care inspection. The completed QIP was returned to the care inspector. 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 of 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. The impact of training was monitored through team meetings, supervision and annual appraisal. Refresher training in medicines management was provided within the last year. Staff had all attended training in safeguarding.

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.

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

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. Additional checks were also performed on other controlled drugs which is good practice.

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 in relation to staff training, competency assessment, the management of medicines on admission, 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. 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. Staff were reminded that bisphosphonates must be administered in accordance with the manufacturers' instructions.

The management of distressed reactions was examined. All of the appropriate records and assessments had been completed. Care plans were in place and administration records were completed appropriately.

The management of pain was examined. All of the appropriate records had been completed and care plans were in place. However, it was found that one resident had not received pain relief in a timely manner on one occasion, as there were no appropriately trained and competent staff on duty to administer medicines in the residential care home. The staff on duty advised that this had previously been raised with management. This omission was discussed with the regional manager at the conclusion of the inspection. Assurance was provided by email following the inspection that the duty rotas had been reviewed to ensure that there were appropriately trained and competent staff on duty to meet the needs of residents. This was also discussed with the care inspector for the home in RQIA who will review staffing during their next inspection. Due to the action taken and the assurance provided, an area for improvement has not been specified on this occasion.

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 the administration of transdermal patches and protocols for the administration of "when required" medicines.

Practices for the management of medicines were audited throughout the month by the staff and management.

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

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

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 the team leader and senior care assistant 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 they were content with their stay. They said that the staff were good, they enjoyed the food and their rooms were comfortable.

None of the questionnaires that were issued were returned within the required timeframe (two weeks). Any comments from patients, patient representatives in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

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

We discussed the 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. They were not examined on this occasion. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

The staffing and skill mix was at times insufficient to meet the health needs of residents. On several occasions through the week, there were no staff on night duty who were trained and competent to administer medicines. On those occasions, day staff were required to remain on duty until the night medicines had been administered. However, should any resident require medicines overnight e.g. pain relief, there was no-one to administer them and no guidance in place for staff to follow to ensure that the residents needs were met. Staff informed us that this arrangement had been in place for several weeks prior to the inspection (see section 6.5).

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 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 with the care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

There were no responses to the online staff questionnaire.

Areas of good practice

There were examples of good practice 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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