Unannounced Post-Registration Medicines Management Inspection Report
1 August 2018

Ashbrook Care Home

Type of service: Residential Care Home
Address: 50 Moor Road, Coalisland, Dungannon, BT71 4QB
Tel No: 028 8774 1010
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 nine 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: Ashbrook Home Ltd **Responsible Individual:** Mr Marcus James Mulgrew	**Registered Manager:** Mrs Gillian Larmour
Person in charge at the time of inspection: Mrs Marina McElvogue (Deputy Manager)	**Date manager registered:** 11 May 2018
Categories of care: Residential Care (RC) I – Old age not falling within any other category.	**Number of registered places:** 9

4.0 Inspection summary

An unannounced inspection took place 1 August 2018 from 10.00 to 12.00.

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 in this newly registered residential care home situated within Ashbrook 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 Mrs Marina McElvogue, Deputy Manager during the inspection and with Mrs Gillian Larmour, Registered Manager by telephone on the day after the inspection, 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 8 February 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 the inspector met with one resident, one relative, the deputy manager and a registered nurse.

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
- medicine audits
- care plans
- training records

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 February 2018

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 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 being managed during the day shift by nurses from the nursing home located in the same building. The registered manager advised by telephone on 2 August 2018 that they were in the process of recruiting and training additional senior care assistants to manage the medicines within the residential home. The induction process for two of these positions should be completed by the end August 2018 (see section 6.7).

Training in the management of medicines for senior care assistants who manage medicines during night duty had been completed. Competency assessments were completed for the night staff. Staff have attended safeguarding training. The registered manager advised that training in the treatment of anaphylaxis was planned for the coming weeks.

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.

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 members of staff. This safe practice 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.

Areas of good practice

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

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 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. The reason for and the outcome of administration were recorded. A care plan was maintained.

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 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. Staff were reminded that obsolete personal medication records should be promptly archived. Areas of good practice were acknowledged. They included additional records for the administration of transdermal patches and reference to the falls policy for those residents prescribed anticoagulants.

Practices for the management of medicines were audited by the staff and management. 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 to one regular visitor to the home who was very complimentary about the home and staff. They advised that they could find no fault with any aspect of care in the home. Their relative had been unwell recently and they were very impressed with how this was handled and the care that was taken when transferring the relative to hospital.

Comments made by this relative included:
"I can find no fault with the care. Staff treat my [relative] with dignity and respect."
"The home is excellent."

We spoke to one resident who advised that they were happy in the home and that the staff were good.

None of the questionnaires that were issued were returned within the timeframe for inclusion in this report (two weeks).

Any comments from residents or their 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

There was evidence that staff listened to residents and relatives 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

Written policies and procedures for the management of medicines were in place. They were not examined during this inspection. 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 team.

A review of the audit records indicated that satisfactory outcomes had been achieved.

The roles and responsibilities in relation to medicines management were discussed in detail with the registered manager. During the inspection, the residential home was being staffed by nurses from the adjoining nursing home and it was noted that there was only one staff rota in use across the building. Following the recent registration process the nursing home and residential care home are now two separate services and require to be managed as such. This was further discussed with the care inspectors for both services for follow up (see section 6.4).

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.

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.

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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