Unannounced Post-Registration Medicines Management Inspection Report 13 September 2018

Corkhill Care Centre

Type of Service: Residential Care Home
Address: 27 Coolmaghery Road, Donaghmore, Dungannon, BT70 3HJ
Tel No:028 8776 7362
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 homewith 12 beds that provides care for residents with a variety of care needs, as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Corkhill Care Centre **Responsible Individual:** Mr Gary George Watt	**Applicant Registered Manager:** Mrs Shona McKeown
Person in charge at the time of inspection: Mrs Shona McKeown	**Date manager registered:** 16 July 2018
Categories of care: Residential Care (RC) DE – Dementia I – Old age not falling within any other category.	**Number of registered places:** 12

4.0 Inspection summary

An unannounced inspection took place on 13 September 2018 from 09.40 to 12.20.

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. 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 medicines governance, medicines administration, medicine records, medicine storage and the management of controlled drugs.

One areafor improvement was identified in relation to care planning.

There was a warm and welcoming atmosphere in the home. Residents were relaxed and good relationships with staff were evident. Staff were knowledgeable about the residents and their likes and dislikes.

4.1Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Maya Mathew, Senior Care Assistant, at the end of the inspection and via telephone with

Mrs Shona McKeown, Registered Manager, on 13 September 2018, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcementaction did not result from the findings of this inspection.

4.2Action/enforcementtaken following the pre-registration inspection

The most recent inspection of the home was an unannounced pre-registration care inspection undertaken on 12 April 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.

During the inspection the inspector met with two care staff, the registered manager and the responsible individual.

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

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

At the request of the inspector, the person-in-charge was asked to display a poster in the home which invited 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
- care plans
- training records
- medicines storage temperatures

The findings of the inspection were provided to the person in charge at the conclusion of theinspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection completed on 12 April 2018

The most recent inspection of the home was an unannounced 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 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 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 members of 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.

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.

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.

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 refrigeratorwas 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 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.

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. However, none of the three residents whose records were examined had a care plan maintained. An area for improvement was identified.

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 management and staff. This included running stock balances for most of the medicines not

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

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and the storage of medicines.

Areas for improvement

A care plan should be in place for any resident prescribed medication for administration on a "when necessary" basis for the management of distressed reactions.

	Regulations	Standards
Total number of areas for improvement	0	1

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 completed in a caring manner, residents were given time to take their medicines and medicines were administered as discreetly as possible.

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 noted to be friendly, courteous and happy in their work; they treated the residents with dignity.

None of the questionnaires that were issued for residents or their representatives to complete were returned.

Areas of good practice

Staff were observed to respond promptly to the needs of residents. There was a warm and friendly atmosphere in the home.

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 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 in place to implement the collection of equality data within Corkhill Care Centre.

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.

The governance arrangements for medicines management were reviewed. Management advised of the daily and monthly audits which take place and how areas for improvement were identified and followed up. This was usually through the development of an action plan and staff supervision. A sample of the audit outcomes was provided.

There were satisfactory 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.

Following discussion with the staff, it was evident that they were knowledgeable regarding their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with the registered manager; and any resultant action was discussed at team meetings and/or supervision. They spoke positively about their work and advised that there were good working relationships in the home with staff, management and with other healthcare professionals. They stated they felt well supported in their work.

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

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Maya Mathew, Senior Care Assistant, at the end of the inspection and via telephone with Mrs Shona McKeown, Registered Manager, on 13 September 2018, 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 standardsthis 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 improvementidentified 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 providershould confirm that these actions have been completed and return the completed QIP via 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 6 **Stated:** First time	The registered person shall ensure that a care plan is in place for any resident prescribed medication for administration on a “when necessary” basis for the management of distressed reactions. Ref: 6.5
To be completed by: 13 October 2018	**Response by registered persondetailing the actions taken:** The Senior Carers have been informed that a care plan is put in place and reviewed monthly or as required when a resident is newly admitted or during their stay they are commenced on medication on a "when necessary" basis for the management of distressed reactions.

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

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