Unannounced Post-Registration Medicines Management Inspection Report 10 April 2018

The Docks Residential Care Home

Type of service: Residential Care Home
Address: c/o Carlingford Lodge Care Home,
76 Upper Dromore Road, Warrenpoint, BT34 3PN
Tel No: 028 4175 9200
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 residential care home is situated on the ground floor of a building that also includes Carlingford Lodge Care Home. The residential care home has 16 beds that provide care and support for residents whose needs are within the old age category of care.

3.0 Service details

Organisation/Registered Provider: Amore (Warrenpoint) Ltd **Responsible Individual:** Mrs Nicola Cooper	**Registered Manager:** Mrs Sara Main
Person in charge at the time of inspection: Mr John Havern (Team Leader)	**Date manager registered:** 5 March 2018
Categories of care: Residential Care (RC) I – Old age not falling within any other category	**Number of registered places:** 16

4.0 Inspection summary

An unannounced inspection took place on 10 April 2018 from 09.50 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 Carlingford Lodge 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 administration and the maintenance of most medicine records.

Areas requiring improvement were identified in relation to medicine records and care planning.

The residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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	2

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mr John Havern, Team Leader, 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 care inspection undertaken on 21 December 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:

- 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 three residents, the team leader, one senior care assistant and the deputy manager of Carlingford Lodge Care Home.

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 21 December 2017

The most recent inspection of the home was an announced 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. All staff managing medicines had recently completed this induction.

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 prescriptions.

There were mostly satisfactory arrangements in place to manage changes to prescribed medicines. Handwritten entries on personal medication records were updated by two members of care staff; this safe practice was acknowledged. However, handwritten entries on medicine administration records were not updated by two members of care staff. The team leader gave an assurance that this matter would be immediately rectified. With this assurance having been given, an area for improvement was not stated.

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.

There were no controlled drugs subject to record keeping requirements. However checks were performed on other controlled drugs, which is good practice.

No discontinued or expired medicines were needed to be disposed of since the home's registration. It was discussed that, because this is a residential care home, medicines for disposal should be returned to the community pharmacy for disposal.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. However, the medicine storage room needed to be rearranged so that the residential care home has its own overstocks medicines storage cupboard and controlled drugs cabinet. This had been identified by management and the team leader stated that both storage units had been ordered. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened.

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 and controlled drugs.

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.

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. Medicines were infrequently used in this manner. 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. However, for the two residents whose records were examined, a care plan was not in place. An area for improvement was identified.

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 the residents could verbalise any pain. 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 generally well maintained and facilitated the audit process. However, for several eye-treatment medicines the route of application was not specified on the personal medication record and medicine administration record. An area for improvement was identified.

Practices for the management of medicines were audited by management.

Following discussion with the staff, it was evident that other healthcare professionals are 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 maintenance of most medicine records and the administration of medicines.

Areas for improvement

When a resident is prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, there should be an accompanying care plan.

The route of application of eye-treatment medicines should be recorded on the relevant records.

	Regulations	Standards
Total number of areas for improvement	0	2

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.

Appropriate arrangements were in place to facilitate residents responsible for the self-administration of medicines.

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.

The residents we spoke with advised that they were content with the management of their medicines and the care provided in the home. They were very complimentary regarding staff and management. Comments made included:

"I receive very good care; the staff are attentive; the food is good."
"The care is very good; the staff couldn't be better."
"I am well looked after; the staff are good."

No completed questionnaires were returned from residents or relatives.

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

6.7 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 in detail. Following discussion with staff it was evident that they were knowledgeable regarding the policies and procedures.

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 largely 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 senior care staff, it was evident that they were knowledgeable 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 advised that management were open and approachable and willing to listen.

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. 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 Mr John Havern, Team Leader, 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 6 **Stated:** First time **To be completed by:** 10 May 2018	The registered person shall ensure that, when a resident is prescribed a medicine for administration on a “when required” basis for the management of distressed reactions, there is an accompanying care plan. Ref: 6.5
	Response by registered person detailing the actions taken: All residents who are prescribed a "When required medication" have accompanying care plans for the medicaiton prescribed. This will be monitored for continued complaince during the internal auditing processes..
Area for improvement 2 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 10 May 2018	The registered person shall ensure that the route of application of eye-treatment medicines is recorded on the relevant records. Ref: 6.5
	Response by registered person detailing the actions taken: The route of application of eye treatment is now recorded on all relevant records This will be monitored for complaince during auditing processes

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

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