The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report
12 March 2018

Laurelhill House

Type of service: Residential Care Home
Address: 1a Ballymacash Park, Lisburn, BT28 3EX
Tel No: 028 9260 2116
Inspector: Judith Taylor

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 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 30 beds that provides care for residents living with a diagnosis of dementia.

3.0 Service details

Organisation/Registered Provider: South Eastern HSC Trust Responsible Individual: Mr Hugh Henry McCaughey	Registered Manager: Ms Mary Laird
Person in charge at the time of inspection: Mr Gareth Gibson, (Senior Care Assistant), until 11.00 and Ms Mary Laird thereafter	**Date manager registered:** 10 March 2015
Categories of care: Residential Care (RC) DE – Dementia	**Number of registered places:** 30

4.0 Inspection summary

An unannounced inspection took place on12 March 2018 from 10.25 to 14.20.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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 during and since the last medicines management inspection 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, training and supervision, the management of medicines changes and the management of controlled drugs.

Areas requiring improvement were identified in relation to the management of distressed reactions, the cold storage of medicines and the completion of medicine records.

Residents spoke positively about 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	*2	*3

*The total number of areas for improvement includes two which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Ms Mary Laird, Registered Manager and Mr Gareth Gibson, Senior Care Assistant, 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 most recent care inspection

The most recent inspection of the home was an unannounced follow up care inspection undertaken on 1 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 home was reviewed. This included the following:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine incidents reported to RQIA since the last medicines management inspection.

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

We met with four residents, two senior care assistants 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
- medicines storage temperatures

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

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 1 February 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and was approved by the care inspector and will be validated at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 15 June 2015

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time	It is a requirement that the registered person reviews the management of medicines to ensure that night-time doses are not being omitted. **Action taken as confirmed during the inspection**: The outcomes of the audit trails indicated that the evening/night-time medicines were being administered as prescribed.	**Met**
Area for improvement 2 **Ref**: Regulation 13(4) **Stated:** First time	It is a requirement that the registered person ensures that all medicines are stored at appropriate temperatures. **Action taken as confirmed during the inspection**: The room temperature of the treatment room was monitored and recorded on a daily basis and was found to be satisfactory. In relation to the cold storage of medicines, there had been no temperature monitoring since November 2017 and there was a large build-up of ice in the medicines refrigerator; this had not been noted by staff. Insulin was stored in this refrigerator and the need to record minimum and maximum temperatures was reiterated. A small number of medicines which did not require cold storage were removed from the medicines refrigerator. Although staff advised	**Not met**

	of the problems regarding cold storage since November 2017 this had not been resolved and the need for adequate cold storage was discussed. This area for improvement has been stated for a second time.	
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 30 **Stated:** First time	It is recommended that the registered person ensures that detailed care plans are in place for the management of distressed reactions for all designated residents. **Action taken as confirmed during the inspection**: Four residents' records were examined. A care plan regarding distressed reactions was in place for two residents; however, there were no details regarding the medicines prescribed. This area for improvement has been stated for a second time.	**Not met**
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time	It is recommended that the registered person ensures that detailed care plans are in place for the management of pain for all designated residents. **Action taken as confirmed during the inspection**: A separate pain management section was maintained in each resident's care file.	**Met**

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. There were arrangements in place to provide refresher training. Staff confirmed that they had received training in dysphagia, medicines management, diabetes awareness and dementia.

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. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training was completed annually.

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.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. This safe practice was acknowledged. However, this did not occur for transcribing medicines details onto medication administration records. An area for improvement was identified.

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. Care plans were in place.

Appropriate arrangements were in place for adding medicines to food to assist with swallowing.

Discontinued or expired medicines were disposed of appropriately.

Most of the 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. In relation to the arrangements for the cold storage of medicines, an area for improvement has been stated for a second time; see Section 6.2.

During the inspection it was noted that one medicine and the corresponding medicine records were being held for one service user, who attends a day centre, which is located on the same site as the residential care home. The medicine was being administered by the residential care home staff in the day centre setting. This was discussed in relation to the registration of the residential care home and also the holding of service user's details. This practice was referred to the relevant senior inspectors for residential care and day care services in RQIA.

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 management of controlled drugs.

Areas for improvement

One area for improvement in relation to the cold storage of medicines has been stated for a second time.

The transcribing of medicine details onto medicine administration records should involve two staff and both staff should initial the entry.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. A few small discrepancies were observed and discussed for close monitoring.

There were arrangements in place to alert staff of when doses of twice weekly or weekly medicines were due. In relation to bisphosphonates staff confirmed that these medicines were administered separately from food or other medicines in accordance with the manufacturers' instructions. It was agreed that staff would be reminded to record the actual time of administration. The registered manager confirmed that this would also be discussed at the upcoming staff meeting.

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. A care plan was obtained for some but not all of the residents prescribed these medicines. An area for improvement has been stated for a second Section 6.2. 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 not recorded and regular use had not been referred to the prescriber for review. 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 most of the residents could verbalise any pain, and a pain assessment tool was used as needed. 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.

Most of the medicine records were well maintained and facilitated the audit process. A small number of the personal medication records required updating in relation to discontinued medicines. When the care staff were responsible for the administration of external

preparations there was no system in place to ensure that this was recorded or monitored. An area for improvement was identified.

Practices for the management of medicines were audited each month by staff and management. The good practice of recording carried forward stock balances for some medicines which were not contained with the 28 day blister pack system was acknowledged. It was suggested that staff should consider recording daily stock balances for other medicines e.g. inhaled medicines, sachets, “when required” medicines. In addition, a quarterly audit was completed by the community pharmacist.

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

Areas of good practice

There were some examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines. Staff were knowledgeable regarding the residents’ medicines.

Areas for improvement

One area for improvement in relation to care plans regarding distressed reactions has been stated for a second time.

The necessary arrangements should be made to ensure that a record of the reason for and the outcome of the administration of medicines for distressed reactions are recorded on every occasion; and any regular use is referred to the prescriber.

The management of delegated tasks should be reviewed to ensure that a record of all administered external preparations is maintained.

	Regulations	Standards
Total number of areas for improvement	1	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 not observed at this inspection. However, following discussion with staff, they confirmed that the residents were given time to take their medicines and medicines were administered as discreetly as possible.

Throughout the inspection, 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 they were familiar with the residents’ likes and dislikes.

The residents we spoke with were very complimentary about the staff, the care provided in the home and the management of their medicines. They advised that any requests they had e.g. pain relief, would be addressed in good time. Comments included:

- "I love it here – this is my home."
- "The staff are really very good."
- "The food is not only good, it is beautiful."
- "I enjoy being here."

Residents who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Of the questionnaires that were issued to receive feedback from residents and their representatives, two were returned. The responses indicated that they were very satisfied/ satisfied with all aspects of the care provided in the home. One comment was made and was shared with the care inspector for the home and also with the manager, who advised that this was being addressed.

"I have no problems with any individual care workers, but for the last six months there appears to be a lot of agency staff coming and going. This makes difficulties for the patient to form a relationship and for the carer to get to know the individual needs."

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.

Written policies and procedures for the management of medicines were in place. These were not examined in detail at the inspection. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents and advised of how staff were made aware of any 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.

Not all of the areas for improvement identified at the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Following discussion with the registered manager and care staff, it was evident that staff were familiar 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 any resultant action was communicated with them through team meetings and supervision. They advised that there were good relationships in the home and with management. The staff we met with spoke positively about their work.

There were no online questionnaires completed by staff within the specified timescale (two weeks).

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

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Mary Laird, Registered Manager and Mr Gareth Gibson, Senior Care Assistant, 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.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 13(4)

Stated: Second time

To be completed by:
11 April 2018</td><td>It is a requirement that the registered person ensures that all medicines are stored at appropriate temperatures.

Ref: 6.2 & 6.4</td></tr>
<tr><td>Response by registered person detailing the actions taken:
A new fridge with internal thermometer is presently being purchased.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Regulation 13(4)

Stated: First time

To be completed by:
11 April 2018</td><td>The registered person shall ensure that the administration of external preparations is recorded on every occasion.

Ref: 6.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Staff to ensure application of external preparations are recorded in residents individual files.</td></tr>
<tr><td colspan="2">Action required to ensure compliance the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 30

Stated: Second time

To be completed by:
11 April 2018</td><td>It is recommended that the registered person ensures that detailed care plans are in place for the management of distressed reactions for all designated residents.

Ref: 6.2 & 6.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Senior staff are presently updating all relevant residents care plans in relation to including management of distressed reactions</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 31

Stated: First time

To be completed by:
11 April 2018</td><td>The registered person shall ensure that any transcribing of medicine details on medication administration records involves two staff and both staff sign the entry.

Ref: 6.4</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Senior staff will ensure that when transcribing medicine details two senior staff will sign entry.
Residents Kardexs have been checked, transcribed and signed by two staff.</td></tr>
</table>

Area for improvement 3 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 11 April 2018	The registered person shall ensure that details of the reason for and the outcome of any medicines administered for distressed reactions are recorded on each occasion; and any regular use is referred to the prescriber. Ref: 6.5
	Response by registered person detailing the actions taken: Senior staff will record reason for and outcome of any medicines administered for distressed reactions in clients file. This will be monitored and regular use will be discussed with perscriber.

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

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