Orchardville House
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BT10 0JH

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Unannounced Medicines Management Inspection of Orchardville House

25 January 2016

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced medicines management inspection took place on 25 January 2016 from 10.00 to 13.40.

The management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no significant areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

This inspection was underpinned by the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Residential Care Homes Minimum Standards (2011).

1.1 Actions/Enforcement Taken Following the Last Medicines Management Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last inspection on 28 February 2013.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	1

The details of the QIP within this report were discussed with the Ms Lorraine Thornton, Senior Care Assistant and Ms Fionnuala McClelland, Assistant Service Manager, South Eastern Health and Social Care Trust as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Belfast HSC Trust/ Mr Martin Joseph Dillon	**Registered Manager:** Not applicable
Person in Charge of the Home at the Time of Inspection: Ms Lorraine Thornton (Senior Care Assistant)	**Date Manager Registered:** Not applicable
Categories of Care: RC-DE	**Number of Registered Places:** 32
Number of Residents Accommodated on Day of Inspection: 26	**Weekly Tariff at Time of Inspection:** £470

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and to determine if the following standards and themes have been met:

Standard 30: Management of medicines
Standard 31: Medicine records
Standard 33: Administration of medicines

Theme 1: Medicines prescribed on a "when required" basis for the management of distressed reactions are administered and managed appropriately.

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately.

4. Methods/Process

Specific methods/processes used included the following:

The management of incidents reported to RQIA since the last medicines management inspection was reviewed.

We met with Ms Lorraine Thornton, Senior Care Assistant.

The following records were examined:

- 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
- training records
- medicines storage temperatures

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 16 July 2015. The completed QIP was returned and approved by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Inspection

Last Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must closely monitor the personal medication record sheets in order to ensure they are being maintained in accordance with DHSSPS guidance.	**Met**
	Action taken as confirmed during the inspection: The personal medication record was observed to have been maintained in a satisfactory manner.	
Last Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	The manager should increase the level of audit activity on boxed medicines.	**Met**
	Action taken as confirmed during the inspection: Running stock balances were maintained for analgesics and several other boxed medicines; weekly audits were also performed on a random selection of boxed medicines.	
Recommendation 2 **Ref**: Standard 30 **Stated:** First time	The Standard Operating Procedures detailing the arrangements for the management of controlled drugs should be reviewed.	**Met**
	Action taken as confirmed during the inspection: The Standard Operating Procedures detailing the arrangements for the management of controlled drugs had been reviewed.	
Recommendation 3 **Ref**: Standard 31 **Stated:** First time	The layout of the personal medication record sheet should be reviewed in order to ensure it meets the needs of the home.	**Met**
	Action taken as confirmed during the inspection: The layout of the personal medication record sheet had been reviewed.	

Recommendation 4 **Ref**: Standard 31 **Stated:** First time	Only the residents' current personal medication record sheets should be kept in the medicines ring-binder file.	**Met**
	Action taken as confirmed during the inspection: Only the residents' current personal medication record sheets were kept in the medicines ring-binder file.	
Recommendation 5 **Ref**: Standard 32 **Stated:** First time	The temperature range of the medicine refrigerator should be monitored and recorded daily.	**Met**
	Action taken as confirmed during the inspection: The temperature range of the medicine refrigerator was monitored and recorded twice daily.	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

Medicines were being administered in accordance with the prescribers' instructions. The audit trails performed on a range of randomly selected medicines produced broadly satisfactory outcomes. The audit on one medicine produced an unsatisfactory outcome; the need to closely monitor the administrations of this medicine was discussed.

Arrangements were in place to ensure the safe management of medicines during a resident's admission to the home. The admission process was reviewed for two recently admitted residents. Their medicine regimes had been confirmed in writing with the prescribers. Two senior care assistants had verified and signed the personal medication records.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. There was no evidence to indicate that medicine doses were omitted due to being out of stock. Medicines were observed to be labelled appropriately.

There was evidence that medicines were prepared immediately prior to their administration from the containers in which they were dispensed.

The medicine records had been maintained in a mostly satisfactory manner. Records of the ordering, receipt, administration and disposal of medicines were maintained. However, the care staff had often not recorded the applications of external medicines. A requirement was made. Where transcribing of medicine details had occurred, this process had involved two staff members to ensure the accuracy of the record; this is good practice. The need to ensure that the resident's allergy status is consistently recorded on their personal medication record sheet was discussed.

Records of the receipt, administration and disposal of all controlled drugs subject to safe custody requirements were maintained in a controlled drug record book. Quantities of controlled drugs matched the balances recorded in the record book.

Records showed that discontinued and expired medicines had been returned to a community pharmacy.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines were in place.

There was evidence that medicines were being managed by staff who had been trained and deemed competent to do so. An induction process was in place. Update medicines management training had been completed by senior care staff within the previous two years. The impact of training was monitored through supervision and appraisal. Competency assessments were completed following the induction period and annually thereafter.

There were robust auditing systems in place for medicines that were administered via the oral route. The senior care assistant stated that the acting manager performed monthly audits. Running stock balances were maintained for analgesics and several other medicines. The senior care staff perform weekly audits on randomly selected medicines. The audit process was facilitated by the good practice of recording the date and time of opening of the medicine container. The need for the auditing process to also include the management of external medicines was discussed.

There were procedures in place to report and learn from medicine related incidents that had occurred in the home. The medicine incidents reported to RQIA since the last medicines management inspection had been managed appropriately.

Is Care Compassionate? (Quality of Care)

The records for a small sample of residents who were prescribed medication for administration on a “when required” basis for the management of distressed reactions were reviewed. For each resident, a care plan in relation to the management of distressed reactions was not in place. A recommendation was made. The parameters for administration were recorded on the personal medication record. The medicines had not recently been administered.

The records for a small sample of residents who were prescribed medicines for the management of pain were examined. The senior carer confirmed that all residents had pain reviewed as part of the admission assessment and on an ongoing basis thereafter. Medicines prescribed for the management of pain were recorded on the residents’ personal medication records. Examination of the administration of these medicines indicated that they had been administered as prescribed. This included analgesics which were prescribed for administration on either a regular or “when required” basis.

Areas for Improvement

The applications of external medicines must always be recorded. A requirement was made.

Where medication is prescribed on a "when required" basis for the management of distressed reactions, there should be a care plan which identifies the parameters for administration. A recommendation was made.

Number of Requirements	1	Number of Recommendations	1

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Lorraine Thornton, Senior Care Assistant and Ms Fionnuala McClelland, Assistant Service Manager, South Eastern Health and Social Care Trust as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained 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 your premises. 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The DHPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and Residential Care Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Person/Registered Manager

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to pharmacists@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Statutory Requirements

Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be Completed by:** 26 February 2016	The registered person must ensure that the applications of external medicines are always recorded. **Response by Registered Person(s) Detailing the Actions Taken:** This requirement was discussed with staff at all levels at a staff meeting on 27 January 2016 and staff were advised of the equal importance of topical medications to medications administered via any other route. Senior staff have agreed to update all cream Kardex and care staff have been advised of their responsibilities in relation to updating these daily. The Manager will ensure that the administration of creams will be included as part of the weekly medication audit.

Recommendations

Recommendation 1 **Ref**: Standard 6 **Stated:** First time **To be Completed by:** 26 February 2016	Where medication is prescribed on a “when required” basis for the management of distressed reactions, there should be a care plan which identifies the parameters for administration. **Response by Registered Person(s) Detailing the Actions Taken:** Senior staff have been made aware that they must now record the reason for the prescription of PRN medication and it's likely outcome, on the individual residents care plan.

Registered Manager Completing QIP	Esther Brimage	**Date Completed**	28/01/16
Registered Person Approving QIP	Martin Dillion	**Date Approved**	
RQIA Inspector Assessing Response	**Paul W. Nixon**	**Date Approved**	**3/3/2016**

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