Unannounced Medicines Management Inspection Report
20 June 2016

611 Ormeau Road

Type of Service: Residential Care Home
Address: 611 Ormeau Road, Belfast, BT7 3JD
Tel No: 028 9504 0583
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of 611 Ormeau Road took place on 20 June 2016 from 09.40 to 11.00.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The management of medicines supported the delivery of safe care. Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. There were no areas of improvement identified. The proactive approach to managing medicine stock and waste within the home is to be commended. There was evidence that the safe systems for medicines management which had been established over time supported the delivery of safe care and positive outcomes for the residents.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure residents were receiving their medicines as prescribed. Appropriate arrangements were in place for the management of pain. There were no areas of improvement identified.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely. The resident consulted with confirmed that they were administered their medicines appropriately. There were no areas of improvement identified.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. The implementation of safe systems and robust auditing arrangements for medicines management that have been well embedded into routine practice has promoted the delivery of positive outcomes for residents over time. There were no areas of improvement identified.

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).

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Catherine Major, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection

1.2 Actions/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection on 20 May 2016.

2.0 Service details

Registered organisation/registered person: Belfast HSC Trust Mr Martin Joseph Dillon	**Registered manager:** Ms Catherine Major
Person in charge of the home at the time of inspection: Ms Catherine Major	**Date manager registered:** 1 April 2005
Categories of care: RC-LD, RC-LD(E)	**Number of registered places:** 13

3.0 Methods/processes

Prior to inspection the following records were analysed:

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

We met with one resident, one senior care assistant and the registered manager.

A sample of the following records was 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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 20 May 2016

The most recent inspection of the home was an unannounced care inspection. The draft RQIA report from that inspection had not yet been issued at the time of this inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection

There were no requirements or recommendations made as a result of the last medicines management inspection on 8 May 2013.

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. The impact of training was monitored through supervision and annual appraisal. Competency assessments were completed annually.

Medicines were ordered on a monthly basis and the prescriptions were received and checked before forwarding to the community pharmacy to be dispensed. The community pharmacist and registered manager have worked together to implement a robust system. Medicines are supplied on a weekly basis and the registered manager advised that this works well in the home and helps to manage stock. From examination of the returned medicines record and the over stock cupboard, it was evident that staff maintain tight control over the quantities of medicines stored in the home. This has been embedded in practice over time, is continually reviewed and ensures that residents have a continual supply of medicines which are appropriately packaged for day care placements and trips away from the home. The proactive approach to managing medicine stock and waste within the home is to be commended.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. The general practitioner was requested to sign the changes when they next visited the resident. This safe practice was acknowledged.

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. The admission process for short stay residents was discussed in detail with the registered manager and safe processes were in place.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. 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.

There was evidence that the safe systems for medicines management, which had been established over time, supported the delivery of safe care and positive outcomes for the residents.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	**0**	**Number of recommendations:**	**0**

4.4 Is care effective?

Examination of the medicines and records indicated that all medicines were administered as prescribed. The registered manager stated that it is very easy to check that medicines had been administered as prescribed due to the system in use.

A small number of residents were prescribed anxiolytic medicines on a "when required" for the management of distressed reactions. It was evident from the records that these medicines were used very infrequently. Staff described techniques that would relieve symptoms in the residents prior to administering these medicines. The reason for and outcome of administering the medicine was recorded in the resident's notes and in the monthly evaluations. It was discussed and agreed with the registered manager that reference to these medicines should be made in the care plan.

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 residents' health were reported to the prescriber.

Medicine records were well maintained and facilitated the audit process.

There were comprehensive and detailed records of every contact with healthcare professionals in the resident's notes.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

4.5 Is care compassionate?

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were knowledgeable regarding their residents' needs, wishes and preferences. Staff and resident interaction and communication demonstrated that residents were treated courteously, with dignity and respect. Good relationships were evident.

Medicines management was discussed with one resident. The resident was satisfied with how medicines were administered. The resident stated that they were given pain relief promptly when they requested it outside of the regular medicine rounds.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. There was evidence that staff were familiar with 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. Medicine related incidents reported since the last medicines management inspection were discussed.

Practices for the management of medicines were audited monthly by the manager. These produced good outcomes. In addition, a quarterly audit was completed by the community pharmacist. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

It was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

There were no requirements or recommendations made at the previous medicines management inspection. Due to the safe systems and the robust auditing system in place there is rarely a discrepancy in the management of medicines. These practices have been embedded and have promoted the delivery of positive outcomes for residents over time.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards.

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