Unannounced Medicines Management Inspection Report
11 May 2017

Bluegate Lodge

Type of service: Residential Care Home
Address: 1 Plantation Road, Garvagh, BT51 5ES
Tel No: 028 2955 7512
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Bluegate Lodge took place on 11 May 2017 from 10.00 to 13.00.

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?

Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was largely in compliance with legislative requirements and standards. One area for improvement was identified in relation to the writing of personal medication records and a recommendation was made.

Is care effective?

The management of medicines largely supported the delivery of effective care. Two areas for improvement were identified in relation to the maintenance of medication administration records and recording dates of opening to facilitate audit. One requirement was stated for the second time and one recommendation was made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for residents. There were no areas for improvement identified.

Is the service well led?

Written policies and procedures for the management of medicines were in place. However, there was limited evidence of audit activity. A robust auditing system should be implemented to ensure staff are following these policies and procedures, to identify any issues and drive the improvements detailed in the report. A recommendation was stated for the second time.

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	1	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Mairead Brolly, Registered Manager, 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.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 22 November 2016.

2.0 Service details

Registered organisation/registered person: Bluegate Lodge Mrs Mairead Bernadette Brolly	**Registered manager:** Mrs Mairead Bernadette Brolly
Person in charge of the home at the time of inspection: Mrs Mairead Brolly	**Date manager registered:** 24 August 2010
Categories of care: RC-DE, RC-I	**Number of registered places:** 5

3.0 Methods/processes

Prior to the inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents - no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with the registered manager and the deputy manager.

Fifteen questionnaires were issued to residents, residents' relatives/representatives and staff, with a request that these were completed and returned to RQIA within one week of the inspection.

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
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 22 November 2016

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

4.2 Review of requirements and recommendations from the last medicines management inspection dated 2 June 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must ensure that records of the administration of all medicines are completed accurately. **Action taken as confirmed during the inspection**: Some improvement in the maintenance of these records was observed and separate antibiotic administration sheets were in use which is good practice. However, some unexplained gaps were observed and for two medicines prescribed for weekly administration, no administration had been recorded for several weeks. It was unclear if these medicines had actually been recorded since the date of opening was not recorded. The actual dose administered for medicines with a variable dose was not usually recorded. The date of opening was not recorded on a number of medicines; therefore an audit trail could not always be completed. The registered manager stated that some of the gaps could be accounted for by the residents' refusal of some medicines. However, this was not recorded. **This requirement was stated for the second time.**	**Not Met**

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	It is recommended that the management of medicines prescribed on a 'when required' basis for the management of distressed reactions is reviewed to ensure that a care plan is in place for their use and that the reason for administration and the outcome are recorded on each occasion.	**Met**
	Action taken as confirmed during the inspection: A care plan was in place and the reason for and outcome of administration was sometimes documented. The reason this was not recorded on every occasion was because regular administration had been authorised by the prescriber for a short period of time. This was recorded in the daily notes.	
Recommendation 2 **Ref**: Standard 30 **Stated:** First time	It is recommended that a robust system of audit of the management of medicines is developed and implemented.	**Not Met**
	Action taken as confirmed during the inspection: No evidence of a robust audit system was in place over recent months, although this is part of the home's own policy and procedures. Of the 37 medicines examined no date of opening was recorded on10 of these, meaning an audit trail was not possible. **This recommendation was stated for the second time.**	

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 team meetings, supervision and annual appraisal. Competency assessments had been completed twice since the last inspection for senior care assistants. Refresher training in medicines management was provided for all relevant care staff in August 2016.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. The registered manager advised of the procedures to identify and report any potential shortfalls in medicines. There were safe systems in place for obtaining and storing any prescriptions until they were dispensed.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were not always updated by two members of staff. The registered manager was reminded that rewritten records and all new entries on personal medication records should be checked for accuracy and signed by two competent members of staff. A recommendation was made.

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. This reconciliation of controlled drugs did not always involve two members of staff as per the homes' own policy and procedures. The registered manager agreed to ensure that this takes place at each transfer of responsibility.

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. Two unlabelled inhalers were observed. The original labelled boxes had been lost. It was advised that original packaging should be in place or the inhalers themselves should be labelled.

Areas for improvement

Personal medication records and all new entries should be checked for accuracy and signed by two competent members of staff. A recommendation was made.

Number of requirements	0	**Number of recommendations**	1

4.4 Is care effective?

The majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. However, some improvements in the standard of maintenance of the medication administration records are necessary. The reason for any omission must be recorded and the actual dose administered for medicines prescribed with a variable dose must be recorded. Regular refusal of prescribed medication should be discussed with the resident and the prescriber. There should be arrangements in place to alert staff when doses of weekly medicines are due (see 4.2). Medicine administration records must be accurately maintained. A requirement made at the last inspection was stated for the second 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 usually recorded. A care plan was maintained (see 4.2).

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. The registered manager advised that for those residents who could not verbalise any pain, staff knew how the residents would express pain.

The registered manager 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.

Records of medicines received and disposed of/transferred were largely well maintained. All regular medicines were appropriately receipted; however two recent antibiotics had not been recorded upon receipt. The registered manager agreed to ensure that all incoming medicines are recorded.

A robust system of audit of the management of medicines was not in place (see 4.2 and 4.6). All medicines should be marked with the date of opening to facilitate audit. A recommendation was made.

Following discussion with the registered manager, it was evident that when applicable, other healthcare professionals were contacted in response to matters relating to medicines management.

Areas for improvement

The registered person must ensure that records of the administration of all medicines are completed accurately. This requirement was stated for the second time.

All medicines should be marked with the date of opening to facilitate audit. A recommendation was made.

Number of requirements	1	**Number of recommendations**	1

4.5 Is care compassionate?

The administration of medicines to residents was observed briefly and was completed in a caring manner. Residents were given time to take their medicines and medicines were administered as discreetly as possible.

We met with two residents and chatted generally about a variety of subjects not specific to the management of medicines. These residents and those 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.

As part of the inspection process, questionnaires were issued to residents, relatives/residents' representatives and staff. Three staff and two relative's questionnaires were returned within the specified timescale. Responses indicated no concerns with the management of medicines in the home.

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. These were reviewed annually. The registered manager was advised to ensure that any updates are highlighted to staff to ensure that policies and procedures are adhered to at all times.

There were arrangements in place for the management of any medicine related incidents. The registered manager confirmed that all relevant staff knew how to identify and report incidents.

A robust system of audit of the management of medicines was not in place. A recommendation made at the last inspection was stated for the second time.

Following discussion with the registered manager, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. The deputy manager confirmed that staff had received training on adult safeguarding and were aware that medication incidents may need to be reported to the adult safeguarding lead.

Not all of the requirements and recommendations made 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.

Areas for improvement

A robust system of audit of the management of medicines should be developed and implemented. This recommendation was stated for the second time.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Mairead Brolly, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 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 provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to the web portal for assessment by the inspector.

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. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Statutory requirements	
Requirement 1 **Ref:** Regulation 13(4) **Stated:** Second time **To be completed by:** 11 June 2017	The registered person must ensure that records of the administration of all medicines are completed accurately.
	Response by registered provider detailing the actions taken: Records all currently up to date and accurate - Report and findings highlighted to all Staff.
Recommendations	
Recommendation 1 **Ref:** Standard 30 **Stated:** Second time **To be completed by:** 11 June 2017	It is recommended that a robust system of audit of the management of medicines is developed and implemented.
	Response by registered provider detailing the actions taken: Audit forms printed and reminders in diary for monthly Audits
Recommendation 2 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 11 June 2017	The registered provider should ensure that personal medication records and all new entries are checked for accuracy and signed by two competent members of staff.
	Response by registered provider detailing the actions taken: Kardex rewritten and Checked and signed by two staff -
Recommendation 3 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 11 June 2017	The registered provider should ensure that all medicines are marked with the date of opening to facilitate audit.
	Response by registered provider detailing the actions taken: All current boxes labelled and findings highlighted to all staff

Please ensure this document is completed in full and returned to the web portal

The Regulation and Quality Improvement Authority

9th Floor

Riverside Tower

5 Lanyon Place

BELFAST

BT1 3BT

Tel 028 9051 7500

Fax 028 9051 7501

Email info@rqia.org.uk

Web www.rqia.org.uk

@RQIANews