Unannounced Medicines Management Inspection Report
19 November 2018

Belmont Cottages

Type of service: Residential Care Home
Address: Racecourse Road, Londonderry, BT48 7RD
Tel No: 028 7137 2350
Inspector: Judith Taylor

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 16 beds that provides care for residents living with learning disability.

3.0 Service details

Organisation/Registered Provider: Apex Housing Association **Responsible Individual:** Mr Gerald Kelly	**Registered Manager:** See box below
Person in charge at the time of inspection: Mr Seamus Crossan	**Date manager registered:** Mr Seamus Crossan (Acting- no application required)
Categories of care: Residential Care (RC) LD – Learning disability LD(E) – Learning disability – over 65 years	**Number of registered places:** 16

4.0 Inspection summary

An unannounced inspection took place on 19 November 2018 from 10.25 to 13.50.

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 governance, training and competency assessment, medicines administration, the completion of medicine records, care planning and the management of controlled drugs.

No areas for improvement were identified at the inspection.

There was a warm and welcoming atmosphere in the home and the residents were observed to be relaxed and comfortable in their environment.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr Seamus Crossan, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the care inspection on 23 September 2018. 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 related incidents reported to RQIA since the last medicines management inspection

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

During the inspection we met with one member of staff and the manager. We also met briefly with four residents.

We provided 10 questionnaires to distribute to residents and their representatives, for completion and return to RQIA and we asked the manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

A sample of the following records was examined during the inspection:

- medicines received
- personal medication records
- medicine administration records
- medicines disposed of
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

We left 'Have we missed you?' cards in the home to inform residents and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

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 23 September 2018

The most recent inspection of the home was an unannounced 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 dated 24 October 2016

Areas for improvement from the last medicines management inspection		
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 31 **Stated:** Second time	The registered manager should ensure that two members of staff verify and sign all hand-written updates on the MARs.	**Met**
	Action taken as confirmed during the inspection: Handwritten entries were rarely required to be written. Staff had been provided with further training regarding record keeping. The manager advised of the audit process around record keeping and advised that staff were aware to do this. Given these assurances this area for improvement has been assessed as met.	

Area for improvement 2 **Ref:** Standard 6 **Stated:** First time	The registered provider should review and revise the management of distressed reactions to ensure that care plans include the name of the prescribed medicine and the parameters for administration. The reason for and outcome of administration should be recorded on all occasions.	**Met**
	Action taken as confirmed during the inspection: A review of records indicated that medicines to manage distressed reactions were infrequently administered. The reason for and the outcome of the administration were recorded. Care plans were in place; however, further detail was necessary in relation to the medicine. Some of these were updated at the inspection and the manager advised by email on 20 November 2018 that all care plans had been updated immediately following the inspection. Given these assurances the area for improvement was assessed as 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. Staff competency assessments were completed following induction, at least annually or more frequently as required. The impact of training was monitored through team meetings, supervision and annual appraisal. Refresher training in the management of medicines and epilepsy was provided earlier this year.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and for the management of medicine changes. Written confirmation of medicine regimes and any medicine changes were obtained. Personal medication records were updated by two trained staff. This is safe practice and was acknowledged.

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, report and follow up any potential shortfalls in medicines.

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

The management of controlled drugs was reviewed. Controlled drugs which require safe custody were not prescribed or held in stock. A system to monitor stock balances of other controlled drugs was in place.

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.

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 changes 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, including time critical medicines. There were arrangements in place to alert staff of when doses of alternate day and fortnightly 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. 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. See also Section 6.2.

The management of pain was examined. Staff advised that none of the residents were prescribed regular pain relief. The medicines were prescribed on the personal medication record and a system was in place to record the reason for and outcome of any administration. Staff advised that some residents could tell staff if they were in pain. For those that couldn't, the manager advised that staff were familiar with how this would be communicated through non-verbal communication for the resident.

The management of swallowing difficulty was examined. When prescribed a thickening agent, this was recorded on the resident's personal medication record and included details of the fluid consistency. A care plan and speech and language assessment report was in place. The processes to record administration were discussed and it was agreed that the fluid consistency would be recorded on the separate administration records from the day of the inspection onwards.

Care plans in relation to epilepsy management were in place.

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 few gaps were noted in one resident's medicine administration records and it was agreed that this would be raised with staff and monitored within the audit process.

Practices for the management of medicines were audited throughout the month by staff and management. Stock balances of some medicines ("when required") medicines were audited each week. A quarterly audit was completed by the community pharmacist.

Following discussion with staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to the residents' needs.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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 during the inspection. Following discussion with staff it was evident they were knowledgeable about the residents' medicines.

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 observation of staff, that they were familiar with the residents' likes and dislikes.

We were unable to obtain the views or opinions from the residents we met with; however, they were noted to be content in the surroundings and interactions with staff.

Of the questionnaires which were left in the home to facilitate feedback from residents and their representatives, none were returned within the time frame (two weeks). Any comments in questionnaires received after the return date will be shared with the manager as necessary.

Areas of good practice

Staff listened to residents and relatives 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.

We 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 were in place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. These were not examined at the inspection.

There were satisfactory arrangements in place for the management of medicine related incidents. The manager advised that all staff knew how to identify and report incidents, and provided details of the procedures in place to ensure that all staff were made aware of incidents and to prevent recurrence.

The governance arrangements for medicines management were examined. We were advised of the auditing and monitoring processes completed and how areas for improvement were shared with staff to address; this was usually at shift handover, team meetings and at supervision.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with the manager.

The staff we met with spoke positively about their work and advised there were good working relationships in the home and with other healthcare professionals. They were complimentary regarding the organisation and the training provided.

No online questionnaires were completed by staff with the specified time frame (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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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