Unannounced Medicines Management Inspection Report
9 March 2017

Seeconnell Private Village

Type of service: Residential Care Home
Address: 119 Clonvaraghan Road, Castlewellan, BT31 9LA
Tel No: 028 4377 1412
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of Seeconnell Private Village took place on 9 March 2017 from 10.15 to 12.30

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?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for residents. 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. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. There were no areas for improvement identified.

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. There were no areas for 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 which promoted the delivery of positive outcomes for residents. Good relationships between staff and residents were evident. There were no areas for 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 share learning from any medicine related incidents and medicine audit activity. There were no areas for 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 Ms Paula Murray, Manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action resulted 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.

2.0 Service details

Registered organisation/registered person: Corriewood Private Clinic Limited Mrs Maria Therese McGrady	**Registered manager:** See below
Person in charge of the home at the time of inspection: Ms Paula Murray	**Date manager registered:** Ms Paula Murray (Acting)
Categories of care: RC-MP, RC-LD	**Number of registered places:** 21

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home

Prior to the inspection, it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with three residents, the registered provider and the manager.

Ten questionnaires were provided for completion by residents, residents' representatives and staff with a request that they were returned within one week of the inspection.

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
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 16 February 2017

The most recent inspection of the home was an unannounced care inspection. There were no requirements or recommendations made following this inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 30 September 2014

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** Second time	The registered person should re-assess the competency of staff with regards to the management of medicines.	**Met**
	Action taken as confirmed during the inspection: Competency assessments were provided for inspection. The manager advised that they were completed annually.	
Recommendation 2 **Ref**: Standard 30 **Stated:** First time	The registered manager should discuss the responsibilities for the administration of prescribed injections with the community nurse and advise RQIA of the outcome.	**Met**
	Action taken as confirmed during the inspection: The community nurse attends the home regularly to administer injections and meet the nursing needs of residents.	

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 were completed annually. Refresher training in medicines management is planned for the coming weeks.

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.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two members of staff. 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 for periods of absence 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.

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. Medicine refrigerators were checked at regular intervals.

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?

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly 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. Comprehensive and detailed care plans were in place for each resident. 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 recorded.

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 resident's health were reported to the prescriber.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged.

Practices for the management of medicines were audited throughout the month by the staff and management.

Following discussion with the manager and staff, it was evident that other healthcare professionals are contacted when required to meet the needs of residents.

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. Residents were treated courteously, with dignity and respect. Good relationships were evident.

Since the last inspection a new outdoor area had been developed with fitness equipment and recreational facilities. Staff advised that the residents enjoyed this outdoor area. Three residents said that they were going to a local fitness class.

The administration of medicines was not observed during this inspection, however staff were very aware of the residents' needs and preferences.

None of the questionnaires that were issued during the inspection were returned within the specified timeframe for inclusion in this report.

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. Management advised that these were reviewed regularly. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

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

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.

Following discussion with the manager 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 and providers.

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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