Action on Hearing Loss
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Londonderry
BT47 6GG

Inspector: Helen Mulligan
Inspection ID: IN022521

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Unannounced Medicines Management Inspection

Of

Action on Hearing Loss

12 May 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced medicines management inspection took place on 12 May 2015 from 10:00 to 13:10.

Overall on the day of the inspection 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 The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last medicines management inspection on 21 May 2012.

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	0	2

The details of the QIP within this report were discussed with Ms Ann Patricia Kelly, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Action on Hearing Loss, Ms Sharon Ford	**Registered Manager:** Ms Ann Patricia Kelly
Person in Charge of the Home at the Time of Inspection: Ms Ann Patricia Kelly	**Date Manager Registered:** 1 April 2005
Categories of Care: RC-LD, RC-MP, RC-SI	**Number of Registered Places:** 6
Number of Residents Accommodated on Day of Inspection: 4	**Weekly Tariff at Time of Inspection:** £1086.41 - £1944.44

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 in this inspection include the following:

Prior to the inspection, the inspector reviewed the management of incidents reported to RQIA since the previous medicines management inspection.

During the inspection the inspector met with three residents, three members of care staff and the registered manager of the home.

The following records were examined during the inspection:

Medicines requested and received
Personal medication records
Medicines administration records
Medicines disposed of or transferred
Medicine audits
Policies and procedures
Care plans
Training records.

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 6 October 2014. The completed QIP was returned and approved by the specialist inspector.

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

Last Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard **30** **Stated twice**	Staff should ensure that medicine supplies are marked with the date of opening	**Met**
	Action taken as confirmed during the inspection: Medicine supplies in use were marked with the date of opening.	
Recommendation 2 **Ref**: Standard **30** **Stated once**	The registered person should ensure that written Standard Operating Procedures are available for the management of controlled drugs.	**Met**
	Action taken as confirmed during the inspection: Written Standard Operating Procedures (SOPs) for controlled drugs were in place. These were reviewed during the inspection and noted to be satisfactory. Records showed that the SOPs were reviewed and updated by the registered manager of the home on 14 January 2013.	
Recommendation 3 **Ref**: Standard **30** **Stated once**	The registered manager should ensure that staff competency with respect to the management of medicines is reviewed on at least an annual basis and records of assessments are maintained.	**Met**
	Action taken as confirmed during the inspection: Records of staff competency assessments were not available during the inspection. On 18 May, the registered manager forwarded evidence by email that staff competency with respect to the management of medicines has been reviewed on an annual basis. The registered manager also advised that staff update training on the management of medicines has been arranged for 16 and 17 June 2015.	

Last Inspection Recommendations		Validation of Compliance
Recommendation 4 **Ref**: Standard **30** **Stated once**	The registered manager should review the auditing process to ensure that it includes some tablet counts of prescribed medicines in the home.	**Met**
	Action taken as confirmed during the inspection: Records showed that medicines not included in the monitored dosage system are audited on a regular basis.	
Recommendation 5 **Ref**: Standard **31** **Stated once**	The registered manager should ensure that personal medication records are marked with the date they are brought into use and photographic identification is labelled with the name of the resident.	**Met**
	Action taken as confirmed during the inspection: All of the personal medication records reviewed during the inspection had been marked with the date they were brought into use. Photographic identification was labelled with the name of the resident.	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

Medicines are administered in accordance with the prescribers' instructions as evidenced by the outcome of a number of audit trails carried out on a randomly selected sample of medicines during the inspection.

The registered manager advised that no new residents have been admitted to the home since the last medicines management inspection on 21 May 2012. The registered manager confirmed that written confirmation of current medication regimes would be obtained from a health or social care professional for any residents admitted to the home.

Systems are in place to manage the ordering of prescribed medicines to ensure adequate supplies are available and to prevent wastage.

There are robust incident reporting systems in place for identifying, recording, reporting, analysing and learning from adverse incidents and near misses involving medicines and medicinal products.

Medicine records were legible and accurately maintained so as to ensure there is a clear audit trail. The registered manager was reminded that any medicine entries on personal medication records that are not signed by the prescriber should be verified and signed by two designated members of staff in the home. A copy of current prescriptions is kept in the home.

The disposal of medicines no longer required was appropriately managed. Supplies for disposal are returned to the community pharmacist who signs the record of disposal.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines, including Standard Operating Procedures for the management of controlled drugs were in place.

Suitable arrangements were in place for the registered manager to ensure that the management of medicines is undertaken by qualified, trained and competent staff and systems are in place to regularly review staff competency in the management of medicines. Records of staff training and competency assessments are maintained.

There are robust arrangements in place to audit all aspects of the management of medicines. A medicines audit is carried out on a monthly basis by a senior member of staff and the registered manager completes three and six-monthly audits. Copies of completed audits were available during the inspection. These records showed that appropriate action was taken when any discrepancies were noted.

One resident is prescribed an injectable medicine on a three-monthly basis. This is administered by the community nursing team. Suitable arrangements were in place to ensure this is managed appropriately.

Is Care Compassionate? (Quality of Care)

The management of medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed for two residents in the home during the inspection. The parameters for administration of these medicines were included on the residents' personal medication records. The management of these medicines was included in the residents' care plans, and daily notes detailing the reason for and outcome of administration are maintained. However, some of the details in the care plans were incomplete. In addition to individual care plans, the home maintains separate records detailing the administration of any "when required" medicines in the home. It is the policy and procedure in this home that staff must contact a senior member of staff to obtain authorisation to administer any "when required" medicines. One resident has not required his prescribed anxiolytic medicine to be administered since 2012. During the inspection, it was noted that the supply of this resident's anxiolytic medicine was out of date at the end of April 2015 and the medicine was removed for disposal. The registered manager advised that the management of this medicine will be reviewed with the prescriber before any further supplies are ordered. Following recent intervention by the prescriber, one resident is now being administered a "when required" anxiolytic medicine on a regular basis and the strength of the anxiolytic medicine has been reduced. During the inspection, the registered manager was advised that the resident's care plan and personal medication record should be updated to reflect this prescription change.

The management of pain was reviewed for three of the residents in the home. Analgesic care plans were in place for each resident and scale of arousal plans which reference pain management are in place where appropriate. Records showed that care plans are reviewed on a three-monthly basis or more frequently when required. Records also showed that one resident recently required regular administration of a medicine which had been prescribed on a "when required" basis for pain relief. As a result of this increased need for pain relief, staff had asked the prescriber to visit the home and review the management of the resident's pain and the medicine is now prescribed for administration on a regular basis. This change was not reflected in the resident's care plan and personal medication record.

Areas for Improvement

Comprehensive and current care plans detailing the management of anxiolytic medicines prescribed on a "when required" basis should be maintained.

Any changes to prescribed analgesic and anxiolytic medicines should be recorded on the resident's personal medication record and care plan.

Number of Requirements:	**0**	**Number of Recommendations**:	**2**

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Ann Patricia Kelly 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 HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The 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 Manager/Registered Person

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	
Recommendations	
Recommendation 1 **Ref**: Standard 30 **Stated: First time** **To be Completed by:** **9 June 2015**	It is recommended that the registered person should ensure comprehensive and current care plans detailing the management of anxiolytic medicines prescribed on an "as required" basis are maintained.
	Response by Registered Person(s) Detailing the Actions Taken: For those who are prescribed anxiolytic medicines one person has had the medication discontinued as it had not been required or administered for a number of years and the care plan for the other person have been updated to include the specific management required for this medication.
Recommendation 2 **Ref**: Standard 30 **Stated: First time** **To be Completed by:** **9 June 2015**	It is recommended that the registered person should ensure any changes to prescribed analgesic and anxiolytic medicines are recorded on the resident's personal medication record and care plan.
	Response by Registered Person(s) Detailing the Actions Taken: All records including the care plan for the person we support are now up to date detailing recent change to medication.

Registered Manager Completing QIP	Patricia Kelly	**Date Completed**	09.06.15
Registered Person Approving QIP	Sharon Ford	**Date Approved**	22.06.15
RQIA Inspector Assessing Response	**Helen Mulligan**	**Date Approved**	**23/06/2015**

Please provide any additional comments or observations you may wish to make below:

Please ensure the QIP is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address