Unannounced Medicines Management Inspection Report
7 June 2016

Mantlin Cottage

Type of Service: Residential Care Home
Address: Mantlin Road, Kesh BT93 1TU
Tel No: 028 6863 1248
Inspector: Helen Mulligan

1.0 Summary

An unannounced inspection of Mantlin Cottage took place on 7 June 2016 from 08:50 to 11:30.

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?

The management of medicines supported the delivery of safe care. Staff who were responsible for 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. No areas for improvement were identified.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. No areas for improvement were identified.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely. No areas for improvement were identified.

Is the service well led?

The service was found to be well led with respect to the management of medicines. There was evidence of excellent practice regarding the management of written policies and procedures, the auditing procedures and staff involvement in the management of medicines. No areas for improvement were 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 Mr Derek Maxwell, 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

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 2 February 2016.

2.0 Service details

Registered organisation/registered person: Praxis Care Group/Challenge Mr Andrew James Mayhew	**Registered manager:** Mr Derek Maxwell
Person in charge of the home at the time of inspection: Mr Derek Maxwell	**Date manager registered:** 1 April 2005
Categories of care: RC-LD, RC-LD(E)	**Number of registered places:** 9

3.0 Methods/processes

Prior to inspection the following records were analysed:

- 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.

During the inspection the inspector met with four residents and three members of staff.

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 care inspection dated 2 February 2016

The most recent inspection of the home was an unannounced care inspection on 2 February 2016. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 30 September 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must review and revise the management of personal medication records to ensure that all medicines prescribed on an "as required" basis are qualified with the frequency of dosing and/or the maximum daily dose.	**Met**
	Action taken as confirmed during the inspection: Personal medication records were well maintained and medicines prescribed on an "as required" basis were qualified with the frequency of dosing and/or the maximum daily dose.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must ensure that records of the administration of medicines are completed at the time each medicine is administered.	**Met**
	Action taken as confirmed during the inspection: Records of medicines administered on the morning of the inspection were complete.	

4.3 Is care safe?

Records showed that medicines were managed by staff that have been trained and deemed competent to do so. An induction process was in place for care staff that had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in the management of medicines was provided on 15 March 2016. The registered manager confirmed that medicines management training has been provided every six months by the community pharmacist and on an annual basis by the registered provider of the home.

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 discharge from the home. Robust arrangements were in place for the management of medicines during periods of home leave.

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. Additional checks were also performed on other controlled drugs which is good practice.

Appropriate arrangements were in place for administering medicines in disguised form. Staff were reminded that pharmaceutical advice should be sought when medicines are added to food to facilitate administration. The completion of care plans for covert administration of medicines was discussed; it was agreed that these would be expanded to ensure all relevant information regarding methods of administration were recorded.

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. Medicine refrigerators and oxygen equipment 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 medicines were due.

Where 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 the 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 on separate records; this good practice was acknowledged. A care plan was maintained.

Pain was managed using medicines included in the home remedy system, which was authorised by the prescriber. Staff were aware that ongoing monitoring was necessary to ensure that any pain was well controlled and the resident was comfortable. A review of recent records showed that staff had correctly assessed that a distressed resident, who was unable to verbalise pain, was experiencing pain and they administered a medicine to control pain rather than administering a medicine for distressed reactions. Records showed that this pain relieving medicine had been effective and the resident was settled and comfortable. This good practice was acknowledged. Staff were reminded that a pain assessment tool should be in place for the management of pain for those residents who cannot verbalise pain. The registered manager confirmed that this would be addressed.

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. They included the use of separate records for the administration of "when required" medicines and carrying forward stock balances of medicines at the beginning of each medicine cycle.

Practices for the management of medicines were audited throughout the month by the staff and management. Staff audit every medicine every day. A full medicines audit was also completed each month. Medicines not supplied in monitored dosage cassettes were marked with the date of opening, which facilitated the audit process. These robust auditing arrangements were highlighted and acknowledged during the inspection.

Following discussion with the registered manager and staff, it was evident that other healthcare professionals are contacted where necessary. Staff on duty reported good working relationships with the prescribers, the community pharmacist and the consultant psychiatrist.

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?

All residents have been assessed for their ability to self-administer medicines. No current residents were self-administering any medicines.

Staff on duty described how medicines were administered according to each individual resident's needs and with regard to the need to maintain dignity and privacy. Staff also reported that medicines were administered to residents in their bedrooms at the weekend to facilitate their wish to remain in bed longer on Saturdays and Sundays.

One resident was able to discuss his medicines. This resident advised he had received his medicines that morning and that he had no problems with pain management. He described how happy he was in the home.

Residents 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.

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. Records indicated that these were reviewed every three years. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff. Records showed that RQIA policies and newsletters had been shared with all staff responsible for the management of medicines. The registered manager had recently introduced a policy whereby a member of staff reviews one of the home's policies and procedures and makes a presentation to the rest of the staff at the team meeting. At the most recent team meeting, records showed that a member of staff had reviewed the home's medicines policies and procedures and presented a comprehensive review of the policies to other staff in the home. This excellent practice was acknowledged during the inspection and demonstrates that the service is well led.

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 satisfactory outcomes had been achieved. Records showed that no discrepancies had been identified, indicating that medicines had been administered as prescribed. Staff explained the procedure that would be followed in the event that a discrepancy was noted and this was confirmed by the registered manager.

Following discussion with the registered manager and care staff, 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 would be raised with management. They advised that concerns regarding the use of "when required" medicines had been identified by staff and raised at a recent team meeting. As a result, the registered manager asked the prescriber to review the management of these medicines for residents in the home. Staff confirmed that a number of these medicines had been discontinued or prescribed on a regular basis as a result. Staff felt this had improved the management of medicines and the care of residents in the home. This excellent practice was acknowledged during the inspection and has promoted the delivery of positive outcomes for residents.

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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