Unannounced Medicines Management Inspection Report
18 April 2016

Creamery House

38 Main Street, Kesh, BT93 1TE
Tel No: 028 6863 2176
Inspector: Helen Mulligan

1.0 Summary

An unannounced inspection of Creamery House took place on 18 April 2016 from 09:00 to 12:15.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern.

Is care safe?

No requirements or recommendations have been made.

Is care effective?

No requirements or recommendations have been made.

Is care compassionate?

No requirements or recommendations have been made.

Is the service well led?

No requirements or recommendations have been made.

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 Lynette McHugh, 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 the actions detailed in the previous QIP, there were no further actions required to be taken following the last inspection on 12 May 2015.

2.0 Service details

Registered organisation/registered person: Western Health and Social Care Trust/Ms Elaine Way CBE	**Registered manager:** Ms Lynette McHugh
Person in charge of the home at the time of inspection: Ms Lynette McHugh	**Date manager registered:** 1 April 2005
Categories of care: RC-LD, RC-LD(E)	**Number of registered places:** 11

3.0 Methods/processes

Prior to inspection, the following records were analysed:

- 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

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

The following records were examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- 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 12 May 2015

The most recent inspection of the home was an unannounced care inspection. No QIP was issued at this inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection on 14 April 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation **13(4)** **Stated:** First time	The registered manager must ensure that the maximum/minimum refrigerator thermometer in the medicines refrigerator is re-set on a daily basis.	**Met**
	Action taken as confirmed during the inspection: Records showed this had been addressed.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 30 **Stated:** Second time	Records of the administration of bisphosphonate medicines should indicate that they have been administered 30 minutes clear of food and other medicines.	**Met**
	Action taken as confirmed during the inspection: This was addressed following the last inspection. There were no bisphosphonate medicines in the home at the time of the inspection.	
Recommendation 2 **Ref**: Standard 31 **Stated:** First time	The registered manager should ensure that liquid medicines are closely monitored and audited on a regular basis.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that, where prescribed, liquid medicines have been included in the auditing process on a regular basis.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 3 **Ref**: Standard 31 **Stated:** First time	The registered manager should ensure that records of the administration of medicines are adequately maintained.	**Met**
	Action taken as confirmed during the inspection: Records of the administration of medicines were adequately maintained and facilitated the audit process.	
Recommendation 4 **Ref**: Standard 30 **Stated:** First time	The registered manager should review the management of anxiolytic medicines.	**Met**
	Action taken as confirmed during the inspection: Robust arrangements for the management of anxiolytic medicines, including comprehensive care plans and records of administration were in place.	

4.3 Is care safe?

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 has been provided every two years and was last provided in April 2015.

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. Robust procedures were in place for obtaining supplies of acute medicines such as antibiotics.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication 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.

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. 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.

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 recorded. A care plan was maintained.

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 pain was well controlled and the resident was comfortable. Staff advised that residents could verbalise any pain. A care plan was maintained.

The management of swallowing difficulties was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record and included details of the required fluid consistency. Administration was recorded and care plans and speech and language assessment reports 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.

Medicine records were well maintained and facilitated the audit process.

Practices for the management of medicines were audited throughout the month by staff and management. This included running stock balances for medicines not supplied in monitored dosage cassettes. In addition, a quarterly audit was completed by the community pharmacist supplying the home.

Following discussion with the registered manager and staff, it was evident that when necessary, other healthcare professionals were contacted regarding the care of residents in the home.

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?

The administration of medicines to residents was completed in a caring manner, residents were given time to take their medicines and medicines were administered as discreetly as possible. Staff administering medicines explained each medicine as it was prepared and administered and encouraged residents to be aware of their medicines and the frequency of administration. Staff discussed recent changes to prescribed medicines with residents during the administration process.

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 and revised in February 2015. 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. Medicine related incidents that were reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents.

A review of the homes' audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and any learning which had resulted in a change of practice.

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 were raised with management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

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 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 exempt the registered person/manager from their responsibility for maintaining compliance with the regulations and standards.

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