Unannounced Medicines Management Inspection Report
6 October 2016

Colorado

Type of service: Residential Care Home
Address: 120 Lisnagole Road, Lisnaskea, BT92 0QF
Tel No: 028 6772 1486
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of Colorado took place on 6 October 2016 from 10.45 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 of 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. The audits completed during this inspection showed that residents were administered their medicines as prescribed. There were no areas of 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. Residents consulted with confirmed that they were administered their medicines appropriately. There were no areas of 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 of 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 Trudie Scott, Deputy 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 QIP there were no further actions required to be taken following the most recent inspection on 26 July 2016.

2.0 Service details

Registered organisation/registered person: Mrs Eileen Elizabeth Scott	**Registered manager:** Mrs Eileen Elizabeth Scott
Person in charge of the home at the time of inspection: Ms Trudie Scott, Deputy Manager	**Date manager registered:** 1 April 2005
Categories of care: RC-DE, RC-PH, RC-I, RC-PH(E)	**Number of registered places:** 9

3.0 Methods/processes

Prior to inspection we analysed the following records:

- 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.

We met with three residents, one care assistant, and the deputy manager.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during 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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 26 July 2016

The most recent inspection of the home was an unannounced care inspection. The QIP from that inspection was due for return on the 5 September 2016, but at the time of this inspection it had not yet been returned. This QIP will be validated by the care inspector at the next care inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 23 September 2013

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	The registered manager should ensure that orders for medicines are made in writing to the prescriber.	**Met**
	Action taken as confirmed during the inspection: All orders had been made in writing and a copy retained.	
Recommendation 2 **Ref**: Standard 30 **Stated:** First time	The registered manager should review and revise the management of anticoagulant medicines to address the issues highlighted in Criterion 30.1 and Criterion 30.2.	**Met**
	Action taken as confirmed during the inspection: The management of anticoagulants had been reviewed and revised. Satisfactory arrangements were in place.	
Recommendation 3 **Ref**: Standard 32 **Stated:** First time	The registered manager should ensure that masks on “spacer” devices for delivering inhaled medicines are kept covered when not in use.	**Met**
	Action taken as confirmed during the inspection: Spacer devices had been placed in separate bags and labelled with the resident’s name.	

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 was provided in the last year.

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

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.

Records of the administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Staff were reminded that the receipt of controlled drugs should also be recorded. 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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

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.

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.

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. Most of the residents could verbalise any pain. A care plan was maintained.

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 management.

Following discussion with the deputy manager and staff, it was evident that when applicable, other healthcare professionals are contacted to meet the needs of the 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?

The administration of medicines was not observed during this inspection as the morning medicines had already been administered. Staff were knowledgeable regarding the resident's needs, wishes and preferences. Staff spoke of the residents with kindness and it was evident that there were good relationships between residents and staff.

The residents told us they were well looked after in the home and that staff were responsive to their needs. Some of the comments included:

"We are spoilt here."
"The staff wait on us hand and foot."

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.

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.

Following discussion with the deputy 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

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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