

# Unannounced Medicines Management Inspection Report 23 February 2017



## Cumulus Heights Residential Services

**Type of service: Residential Care Home**  
**Address: 3-5 Cumulus Heights, Ballyvange, Downpatrick,  
Down, BT30 6WT**  
**Tel No: 02844617184 (Option 4)**  
**Inspector: Paul Nixon**

## 1.0 Summary

An unannounced inspection of Cumulus Heights Residential Services took place on 23 February 2017 from 09:30 to 12:00.

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 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. 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 cascade 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
<b>Total number of requirements and recommendations made at this inspection</b>	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Miss Laura Torney, 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 QIP there were no further actions required to be taken following the most recent inspection on 7 February 2017.

## 2.0 Service details

<b>Registered organisation/registered person:</b> Mainstay DRP Mrs Helen Owens	<b>Registered manager:</b> Ms Laura Torney
<b>Person in charge of the home at the time of inspection:</b> Ms Laura Torney	<b>Date manager registered:</b> 22 October 2015
<b>Categories of care:</b> RC-LD, RC-LD(E)	<b>Number of registered places:</b> 24

## 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.

During the inspection, the inspector met with two residents, the registered manager and two care staff.

Twenty-five questionnaires were issued to residents, residents' representatives and staff with a request that they were returned within one week from the date of this inspection.

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.

The following records were 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 inspection dated 7 February 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be reviewed by the care inspector once it is returned to RQIA. 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 25 February 2016

There were no requirements or recommendations made as a result of the last medicines management inspection.

### 4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for care staff who 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 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. 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 medicine 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 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.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	0
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#### 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 the pain was well controlled and the resident was comfortable. Staff advised that most of the residents could verbalise any pain.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record; however, this did not include details of the fluid consistency. The registered manager gave an assurance that this matter would be addressed without delay. Administrations were 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 the staff and management. This included weekly audits on all medicines and also audits on all medicines returned to residents at the end of their period of respite stay. In addition, periodic audits were completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that, when applicable, other healthcare professionals are contacted in response to residents' needs.

**Areas for improvement**

No areas for improvement were identified during the inspection.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	0
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**4.5 Is care compassionate?**

With the exception of one resident, the administration of the morning medicines round had been completed before the inspection commenced. The administration of medication to this resident was completed in a caring manner.

Residents spoken to advised that they were very satisfied with the care experienced. 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.

As part of the inspection process, we issued questionnaires to residents, residents' representatives and staff. No questionnaires were returned within the specified timeframe.

**Areas for improvement**

No areas for improvement were identified during the inspection.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	0
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**4.6 Is the service well led?**

Written policies and procedures for the management of medicines were in place. 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 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.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	0
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## 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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