Unannounced Medicines Management Inspection Report
22 February 2017

Thackeray Place

Type of Service: Residential Care Home
Address: 12 Ballyclose Street, Limavady, BT49 0BN
Tel No: 028 7776 3011
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Thackeray Place took place on 22 February 2017 from 10.40 to 15.00.

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. No requirements or recommendations were made.

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. Areas of medicines management were detailed in the sample of residents' care plans examined. No requirements or recommendations were made.

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. No requirements or recommendations were made.

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. No requirements or recommendations were 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 Mr Patrick Travers, 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

There were no further actions required to be taken following the most recent inspection on 15 November 2016.

2.0 Service details

Registered organisation/registered person: Western HSC Trust /Ms Elaine Way CBE	**Registered manager:** Mr Patrick Travers
Person in charge of the home at the time of inspection: Mr Patrick Travers	**Date manager registered:** 21 November 2016
Categories of care: RC-A, RC-I	**Number of registered places:** 32

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.

During the inspection the inspector met with three residents, one member of senior care staff, one relative and the registered 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.

Nineteen questionnaires were issued to residents, relatives/resident representatives and staff, with a request that were completed and returned within one week of the inspection.

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 inspection dated 15 November 2016

The most recent inspection of the home was an unannounced care inspection. No requirements or recommendations were made.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 6 May 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must put robust arrangements in place for the management of calcium supplements to ensure that these medicines are being administered as prescribed.	**Met**
	Action taken as confirmed during the inspection: The auditing process had been reviewed. These medicines were included in the audit process. No further concerns were noted in the management of these medicines and the audit trails undertaken at the inspection produced satisfactory outcomes.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	The registered manager should closely monitor the administration of nebivolol tablets and alendronic acid tablets; any further discrepancies should be investigated and reported to RQIA.	**Met**
	Action taken as confirmed during the inspection: There was evidence that these medicines were regularly included in the auditing process; records indicated that satisfactory outcomes had been achieved. This correlated with the outcomes of the audit trails undertaken at the inspection.	

Recommendation 2 **Ref**: Standard 30 **Stated:** First time	The registered manager should ensure that the recording system in place for residents who are prescribed 'when required' anxiolytic / antipsychotic medicines, includes the relevant records as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: Two residents were prescribed these medicines. The details were clearly recorded on their personal medication record. Staff advised that they knew to record the reason for and outcome of any administration, but advised that these medicines were never administered as the residents did not require them. A care plan was not maintained as these were not in current use and this was discussed. The registered manager agreed to contact the prescriber after the inspection. As written this recommendation has been partially met; however, following the assurances provided by the registered manager, it was assessed as met.	

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 included the completion of a test and these were completed as part of the appraisal process. Refresher training in the management of diabetes had been recently completed.

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 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.

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.

Robust arrangements were observed for the management of high risk medicines, e.g. warfarin and insulin. The care plan in relation to diabetes was discussed and it was agreed that this would be developed to include more detail with immediate effect.

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 were checked at regular intervals. A record of the transfer of medicine keys was maintained.

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. It was acknowledged that a system was in place to record dates and stock levels of three monthly injections administered by community nurses.

A staff communication book was maintained and viewed at each shift change. This included information regarding medicines and the outcomes of visits from/consultation with other healthcare professionals.

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 residents could verbalise pain. Details of pain management were recorded in the sample of care plans examined.

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. The good practice of recording paracetamol warning alerts when a resident was prescribed two medicines containing paracetamol was acknowledged.

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

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?

Appropriate arrangements were in place to facilitate residents responsible for the self-administration of medicines.

The administration of medicines to residents was completed in a caring manner and residents were given time to take their medicines.

Throughout the inspection, it was found that there were good relationships between the staff and the residents. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was evident that staff were familiar with the residents' likes and dislikes.

Residents advised that they had no concerns regarding the management of their medicines and were very complimentary regarding their care and the attention provided by staff. They stated that staff would response in a timely manner for any requests, including pain relief. Some of the comments included:

"you couldn't get any better"
"I am settled well"
"the staff are very, very good"

One relative advised that the family were very happy with the care of their relative in the home.

As part of the inspection process, questionnaires were issued to residents, relatives/resident representatives and staff. Thirteen questionnaires were returned. The responses were recorded as 'very satisfied' or 'satisfied' with the management of medicines in the home.

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. 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 arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents.

A robust auditing system for medicines management was in place. Audits were completed on a regular basis. An overarching audit was completed by the registered manager every month and in addition audits were completed by the community pharmacist. A review of the internal audit records indicated that largely satisfactory outcomes had been achieved. Staff advised of the procedures undertaken when discrepancies or areas for improvement were identified.

As part of the governance processes within the home, a weekly management meeting was held.

Following discussion with the registered manager and 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. They advised that any resultant action was communicated to staff individually and through the communication book.

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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