Unannounced Medicines Management Inspection Report
12 April 2017

William Street Care Home

Type of service: Residential Care Home
Address: 98 William Street, Londonderry, BT48 9AD
Tel No: 028 7126 4213
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of William Street Care Home took place on 12 April from 10.30 to 14.30.

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 some areas of the management of medicines supported the delivery of safe care and positive outcomes for residents. There were records indicating that staff administering medicines were trained and competent. However, areas for improvement were identified in relation to the management of medicine changes and controlled drugs records. Three recommendations were made.

Is care effective?

Some areas of the management of medicines supported the delivery of effective care. Whilst the majority of medicines were administered as prescribed, there were weaknesses identified in the management of inhaled medicines and antibiotics, the standard of record keeping and management of distressed reactions. Two requirements and two 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. There were no areas of improvement identified.

Is the service well led?

Some areas of the service were 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. In relation to the governance arrangements, robust systems were not in place to audit all aspects of medicines management and to manage medicine related errors or audit outcomes. Two requirements 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	4	5

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Moia Irvine, Registered Manager and one senior care assistant on duty, as part of the inspection process. The timescales for completion commence from the date of inspection.

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 21 February 2017.

2.0 Service details

Registered organisation/registered person: Western HSC Trust/ Mrs Elaine Way CBE	**Registered manager:** Mrs Moia Patricia Irvine
Person in charge of the home at the time of inspection: Mrs Moia Patricia Irvine	**Date manager registered:** 1 April 2005
Categories of care: RC-I	**Number of registered places:** 27

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the incidents register – it was ascertained that no medicine related incidents had been reported to RQIA since the last medicines management inspection.

During the inspection the inspector met with two residents, one member of senior care staff, one member of care staff, one visiting professional 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. No one availed of this opportunity during the inspection.

Fifteen questionnaires were issued to residents, their relatives/representatives and staff in relation to medicines management, with a request that these were 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
- care plans
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 21 February 2017

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

4.2 Review of requirements and recommendations from the last medicines management inspection dated 4 August 2014

No requirements were made.

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	The registered manager should implement additional monitoring arrangements for nutritional supplements.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that nutritional supplements had been closely audited with immediate effect following the last medicines management inspection. At that time a number of residents were prescribed this medicine and significant quantities of stock was held. However, the number of residents prescribed these had reduced to one resident. Staff confirmed that stock levels were monitored as part of the monthly ordering process.	

Recommendation 2 **Ref**: Standard 32 **Stated:** First time	The registered manager should ensure that records of checks of stock balances of controlled drugs at each handover of responsibility are adequately maintained.	**Met**
	Action taken as confirmed during the inspection: With the exception of one controlled drug awaiting disposal, stock reconciliation checks were performed on controlled drugs subject to safe custody at each shift change and signed by two staff. This was discussed and the registered manager confirmed that the need to reconcile all controlled drugs would be raised with all designated staff. Given this assurance this recommendation was assessed as met.	

4.3 Is care safe?

The registered manager confirmed that there were arrangements in place to ensure that staff were provided with training in medicines management. Staff competencies were assessed through quarterly supervision and annual appraisal. A sample of records was provided. In addition, the registered manager advised that she attended the Western HSC Trust medicines management group and cascaded information to staff as necessary. However, due to the inspection findings as detailed in the report, further medicines management training including accountability should be completed. A recommendation was made.

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. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed in June and July 2016.

The arrangements in place to manage medicine changes, including high risk medicines such as warfarin and new residents' medicines were examined. The transcribing of medicines information on personal medication records and warfarin records were not always updated by two members of staff. To ensure safe practice a recommendation was made.

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 (CDRB). It was noted that there were recording errors and one incomplete entry in the CDRB. Checks were performed on controlled drugs which require safe custody, at the end of each shift (see also Section 4.2) and also diazepam, which is good practice. Staff had also recorded the checks in

the date column of the CDRB; this had been discussed at the previous medicines management inspection and should not occur. A recommendation regarding record keeping was made.

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

Staff should be provided with further training in medicines management. A recommendation was made.

Two designated staff should be involved in any transcribing of medicine details in medicine records. A recommendation was made.

The completion of records pertaining to controlled drugs should be reviewed. A recommendation was made.

Number of requirements	0	**Number of recommendations**	3

4.4 Is care effective?

Most of the medicines selected for audit, had been administered in accordance with the prescriber's instructions. However, there were discrepancies noted in inhaled medicines and antibiotics and these were highlighted at the inspection. For one antibiotic the course had been completed three days late. A recommendation was made. It was suggested that a record of the stock balance of these medicines after each administration, should be maintained.

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 or three monthly medicines were due.

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. A care plan was maintained. 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 not always recorded. It was noted that for one resident there was regular administration of these medicines. Any ongoing administration of these medicines should be referred to the prescriber. A recommendation was made.

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 the residents could verbalise any pain.

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.

Some of the medicines records were maintained in the required manner. However, in relation to the administration of medicines records, errors were noted and the practice of code-copying had occurred. Following discussion with staff it was confirmed that an original record had been removed and destroyed due to the identification of code copying; and replaced with a new completed record. This had not been reported to the registered manager. Original records must only be destroyed in line with the organisation's records management policies. The registered manager must investigate this issue. A requirement was made. Care staff were responsible for the administration of some external preparations, a record of each administration was not maintained. Advice was given at the inspection. A requirement regarding the completion of medicine administration records was made.

At the time of the inspection, one external preparation was being self-administered. Staff confirmed that this was well managed. However, the relevant records were not in place and this was discussed in relation to the risk assessment/care plan, storage and monitoring arrangements. It was agreed that this would be addressed following the inspection.

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

Areas for improvement

The administration process for antibiotics and inhaled medicines should be closely monitored. A recommendation was made.

The management of distressed reactions should be reviewed to ensure that the reason and outcome of each administration is recorded and any regular administration is referred to the prescriber. A recommendation was made.

The registered manager must investigate the observations made regarding the removal and destruction of original records. A requirement was made.

Medicine administration records must be fully and accurately maintained at all times. A requirement was made.

Number of requirements	2	**Number of recommendations**	2

4.5 Is care compassionate?

Staff advised that were possible residents were encouraged to look after their own medicines.

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.

There was evidence of good relationships between the staff and patients.

The residents spoken to advised that they were satisfied with the manner in which their medicines were managed and administered. They advised that they had no concerns regarding their care in the home and were very complimentary about the staff and the food.

As part of the inspection process, questionnaires were issued to residents, their relatives/representatives and staff. There were no questionnaires received by RQIA at the time of issuing this report.

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. The registered manager advised that these were under review and development and would be shared with staff in due course.

The management of medicine related incidents was reviewed. There had been no medicine related incidents reported to RQIA in the last five years. Although staff advised of the procedures that would be followed when an incident occurred, two incidents in relation to medicines administration were noted at the inspection. There was no evidence that the incidents had been reported within the organisation or to RQIA. This suggests that staff were not familiar with issues/discrepancies that should be recognised as a medicine related incident. A requirement was made.

There was limited evidence to indicate that the governance arrangements for medicines management were robust. Whilst it was recognised that there was an auditing system in place, the findings indicated that this was not effective in managing errors and discrepancies (see earlier sections). A requirement was made.

Following discussion with management, they confirmed that staff were aware of their roles and responsibilities. However, the findings of the inspection indicate that these should be reiterated with staff. A recommendation regarding training and accountability was made in Section 4.3.

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.

Areas for improvement

The management of recording errors and audit outcomes must be reviewed to ensure that management are informed and these are managed in line with legislation and professional standards. A requirement was made.

The governance arrangements for medicines management must be reviewed to ensure that a robust auditing process is in place. A requirement was made.

Number of requirements	2	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Moia Irvine, Registered Manager and one senior care staff, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to pharmacists@rqia.org.uk for assessment by the inspector.

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. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 13 April 2017	The registered provider must ensure that the finding in relation to the removal and destruction of original records is investigated.
	Response by registered provider detailing the actions taken: Member of staff responsible for making this error was given update in her training and a reviewed competency assessment and will be closely supervised by the registered manager.
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 13 April 2017	The registered provider must put robust arrangements in place to ensure that medicine administration records are fully and accurately maintained at all times.
	Response by registered provider detailing the actions taken: Registered manager is carrying out weekly monitoring audits on the records of administration of medication within the residential Home.
Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 13 April 2017	The registered provider must develop a robust audit process for medicines management.
	Response by registered provider detailing the actions taken: Enhanced auditing of all medication is taking place.
Requirement 4 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 13 April 2017	The registered provider must review the management of recording errors and audit outcomes to ensure that management are informed and these are managed in line with legislation and professional standards.
	Response by registered provider detailing the actions taken: All senior staff have been made aware that any discrepancies or errors identified in audits are brought to the attention of the registered manager who will carry out further investigations and reporting if necessary.
Recommendations	
Recommendation 1 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 13 April 2017	The registered provider should provide further training for staff in medicines management and their professional accountability.
	Response by registered provider detailing the actions taken: All Staff who have responsibility for administration of medicines have been given an update in training and a review of their competency assessment. This included sharing the requirements and recommendations of the pharmacy inspection. Training on medicines management including administration of topical medication is to be given to staff by our community pharmacist in June.

Recommendation 2 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 13 April 2017	The registered provider should ensure that two designated staff are involved in the writing and updating of medicine records.
	Response by registered provider detailing the actions taken: This has been reiterated to all senior staff and will be closely monitored by the registered manager.
Recommendation 3 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 13 April 2017	The registered provider should ensure that records pertaining to controlled drugs are accurately maintained.
	Response by registered provider detailing the actions taken: Recent training given to senior staff by the registered manager included requirements regarding the recording and monitoring of controlled drugs.
Recommendation 4 **Ref**: Standard 33 **Stated:** First time **To be completed by:** 13 April 2017	The registered provider should closely monitor the administration of inhaled medicines and antibiotics to ensure these are administration in accordance with the prescribers' instructions.
	Response by registered provider detailing the actions taken: Enhanced monitoring of antibiotics and inhaled medication is being carried out.
Recommendation 5 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 13 April 2017	The registered provider should review the management of distressed reactions as detailed in the report.
	Response by registered provider detailing the actions taken: A care plan with regard to medication given for distressed reactions and outcomes has been introduced for individual residents.

Please ensure this document is completed in full and returned to pharmacists@rqia.org.ukfrom the authorised email address*

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