Unannounced Medicines Management Inspection Report
12 January 2018

Limetree House

Type of service: Residential Care Home
Address: 133/133A Comber Road, Dundonald, BT16 2BT
Tel No: 028 9048 9380
Inspector: Helen Daly

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a residential care home with 35 beds that provides care for residents who are living with dementia.

3.0 Service details

Organisation / Registered Provider: Mrs Gertrude Alexandra Priscilla Nixon	**Registered Manager:** See box below
Person in charge at the time of inspection: Mr Graham Moore	**Date manager registered:** Mr Graham Moore – acting, no application
Categories of care: Residential Care (RC) DE – dementia	**Number of registered places:** 35

4.0 Inspection summary

An unannounced inspection took place on 12 January 2018 from 10.00 to 13.40.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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).

The inspection assessed progress with any areas for improvement identified during and since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to medicines administration, medicine records and medicine storage.

Areas requiring improvement were identified in relation to the management of warfarin and eye preparations.

The residents we spoke with were complimentary about the management of their medicines and the care provided in the home.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	*2

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mr Graham Moore, Manager, 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.

4.2 Action/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 12 December 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the home was reviewed. This included the following:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection we met with three residents, two care assistants, a senior care assistant and the manager.

A total of 10 questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

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
- medicines storage temperatures

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 12 December 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 26 November 2015

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 30

Stated: First time</td><td>The management of warfarin should be reviewed to ensure that staff are able to refer to the original dosage directions at each administration and where transcribing is necessary, a second member of trained staff checks and signs the record to ensure accuracy.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A warfarin administration chart was in place. Dosage directions were clearly recorded and a running stock balance was maintained.

However, the dosage directions had not been received in writing and two members of staff had not signed and verified the transcribing.

This area for improvement was stated for a second time.</td></tr>
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Area for improvement 2 **Ref**: Standard 31 **Stated:** First time	Records regarding the management of diabetes should be reviewed to ensure that prescribed insulin is included on the personal medication record and that a care plan is maintained for the management of hypo/hyperglycaemia for each identified resident.	**Met**
	Action taken as confirmed during the inspection: When prescribed, insulin was recorded on the personal medication records. Care plans were maintained for the management of hypo/hyperglycaemia for each identified resident. In addition detailed guidance on identifying and managing hypo/hyperglycaemia was available in the treatment room.	
Area for improvement 3 **Ref**: Standard 32 **Stated:** First time	Arrangements should be reviewed to ensure that the temperature of the medicines storage room is maintained at or below 25°C at all times.	**Met**
	Action taken as confirmed during the inspection: The daily records for the room temperature indicated that the temperature of the medicines storage room was maintained at or below 25°C.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The manager confirmed that medicines were managed by staff who have been trained and deemed competent to do so. Training was provided annually by the community pharmacist. Competency assessments were also completed annually. The manager advised that training on the regional safeguarding procedures was planned.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. There was evidence that antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were mostly satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. A small number of handwritten entries on medication administration records had not been verified and signed by two members of staff; this was discussed and the manager agreed to monitor this closely.

There were procedures in place to ensure the safe management of medicines during a resident's admission to 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. It was noted that one recently prescribed controlled drug had not been stored in the controlled drugs cupboard or entered in the controlled drug record book; this was addressed during the inspection.

Mostly satisfactory arrangements were in place for administering medicines in disguised form. The prescriber and family had provided authorisation. Guidance on the suitability of adding the medicine to food/drink had not been confirmed with the pharmacist; this was addressed during the inspection and it was agreed that a detailed care plan would be put into place.

Discontinued or expired medicines were returned to the community pharmacist for disposal.

Medicine storage areas were clean, tidy and well organised. The majority of medicines were stored safely and securely and in accordance with the manufacturer's instructions. However, dates of opening were not recorded on a number of eye preparations and insulin pen devices. An area for improvement with regards to eye preparations was made in Section 6.5 and it was agreed that the management of insulin pens would be discussed with the district nursing team. The maximum, minimum and current refrigerator temperatures were monitored and recorded each day. Temperatures below 2^{o}C were observed on some days; this was discussed with the manager and senior carer, who agreed to take corrective action if necessary.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment and the management of medicines on admission.

Areas for improvement

No new areas for improvement were identified during the inspection.

The management of warfarin should be reviewed and revised (See Section 6.2).

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The majority of medicines examined had been administered in accordance with the prescriber's instructions. However it was noted that two eye preparations had been signed as administered for four days but the containers had not been opened. The manager agreed to discuss this finding with staff. In addition dates of opening had not been recorded for two eye preparations. An area for improvement was identified.

There were arrangements in place to alert staff of when doses of early morning and weekly 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. Care plans were in place. 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 had been recorded on most occasions.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. There was evidence that pain was reviewed regularly.

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.

Following discussion with the manager and staff, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in resident care.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

The management of eye preparations should be closely monitored to ensure that these medicines are administered as prescribed. Dates of opening should be recorded to facilitate disposal at expiry.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff were knowledgeable about the administration of medicines and guidance was displayed in the medicine room for easy reference.

We observed the administration of medicines to several residents over the lunch time period. The senior care assistant administering the medicines spoke to the residents in a kind and caring manner and the residents were given time to swallow their medicines.

We observed lunch; residents were observed to enjoy fish and chips and ice cream sliders followed by tea/coffee and a selection of biscuits. The atmosphere was relaxed and staff were chatting with the residents.

The residents we spoke to at the inspection were very happy with the care provided in the home. Comments included:

- "It's very good here; you wouldn't get better staff anywhere."
- "I had a lovely lunch. The music man is coming now, he's very good."

Care assistants were complimentary about the home. Comments included:

- "It is a great home. You get lots of training. I love working here and you get to know all the residents."
- "You get to know your residents; they become part of your family."

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As part of the inspection process, we issued 10 questionnaires to residents and their representatives; none were returned within the specified timescale.

Areas of good practice

Staff listened to residents and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Written policies and procedures for the management of medicines were in place; they were not reviewed at the inspection.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. The manager confirmed that staff were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. The manager and senior carer advised that staff work very closely so any issues would be discussed immediately for corrective action.

Following discussion with the manager and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

One area for improvement identified at the last medicines management inspection had not been addressed. To ensure that these are fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that management were open and approachable and willing to listen.

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mr Graham Moore, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 30 **Stated:** Second time **To be completed by:** 12 February 2018	The management of warfarin should be reviewed to ensure that staff are able to refer to the original dosage directions at each administration and where transcribing is necessary, a second member of trained staff checks and signs the record to ensure accuracy. Ref: 6.2
	Response by registered person detailing the actions taken: Policy and procedure updated and signed by relevant staff. Sheet added with original dosage directions and witnessed and signed by two trained staff. Completed 15/01/2018
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 12 February 2018	The registered person shall ensure that the management of eye preparations is reviewed and revised. Ref: 6.4 and 6.5
	Response by registered person detailing the actions taken: All staff made aware of this area for improvement. Manager will carry out regular audits to ensure procedure is being completed correctly. Completed 13/01/2018

Please ensure this document is completed in full and returned via the Web Portal

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