Unannounced Medicines Management Inspection Report
8 June 2017

The Cottages

Type of service: Residential Care Home
Address: Shepherds Way, Dungiven Road, Derry, BT47 5GW
Tel no: 028 7134 4484
Inspector: Judith Taylor

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 seven beds that provides respite care for adults living with a learning disability.

3.0 Service details

Organisation/Registered Provider: Western HSC Trust **Responsible Individual:** Mrs Elaine Way CBE	**Registered Manager:** See below
Person in charge at the time of inspection: Ms Janet Doherty	**Date manager registered:** Ms Janet Doherty – Acting - No application required
Categories of care: Residential Care (RC) LD - Learning Disability LD(E) - Learning Disability - over 65 years	**Number of registered places:** 7

4.0 Inspection summary

An unannounced inspection took place on 8 June 2017 from 10.20 to 12.50.

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).

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 the governance arrangements for medicines, the standard of record keeping and care plans, management of medicines at admission and storage of medicines. The improvements and progress made since the last medicines management inspection were acknowledged.

No areas for improvement were identified at the inspection.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Janet Doherty, Manager, and the team leader on duty, 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.

4.2 Action/enforcement taken following the most recent care inspection

No further actions were required to be taken following the most recent inspection on 31 March 2017.

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 service 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

During the inspection the inspector met with the team leader and the registered manager. We also met briefly with a group of staff and one resident.

A total of 15 questionnaires were provided for distribution to residents, their representatives, and staff for completion and return to RQIA.

A sample of the following records was examined during the inspection:

- medicines received
- personal medication records
- medicine administration records
- medicines transferred
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records

Areas for improvements 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 31 March 2017

The most recent inspection of the home was an unannounced care inspection. There were no areas for improvements made as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 16 September 2014

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** Second time	Policies and procedures for confirming medicines on admission must be reviewed and revised to ensure that there is evidence that current medication regimes have been confirmed at each admission, all personal medication records are accurate and current, and all prescribed medicines are included.	**Met**
	Action taken as confirmed during the inspection: New systems had been implemented to ensure that up to date medicine information was received at each period of respite care. This included a printed medicine list and a copy of the resident's electronic care record. The personal medication records were verified by two trained staff.	
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** Second time	Medicines must be administered in accordance with the prescribers' instructions.	**Met**
	Action taken as confirmed during the inspection: The outcomes of the inspection indicated that medicines had been administered as prescribed.	

Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** Second time	Personal medication records must be adequately maintained, in accordance with DHSSPS guidance.	**Met**
	Action taken as confirmed during the inspection: A new format of personal medication record had been developed and implemented. This format was more suitable for use. Those selected for examination had been well maintained.	
Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that care workers responsible for the administration of external preparations are trained and competent; and records of training and competency assessment are maintained.	**Met**
	Action taken as confirmed during the inspection: Following a review of staff roles and responsibilities, all care staff had completed or commenced training in medicines management. A sample of training and competency assessment records were provided at the inspection.	
Area for improvement 5 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that records of the administration of medicines are fully and accurately maintained on every occasion.	**Met**
	Action taken as confirmed during the inspection: The sample of medicine administration records examined had been well maintained.	
Area for improvement 6 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must review the arrangements in place for the management of keys to ensure that all medicines are stored securely and can only be accessed by those members of staff who have been trained and deemed competent to manage and administer them.	**Met**
	Action taken as confirmed during the inspection: The key control, security and accessibility of medicines had been reviewed; safe arrangements were in place. A daily log book was maintained to record the staff involved in the transfer and acquisition of keys.	

Action required to ensure compliance with The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		Validation of compliance
Area for improvement 1 **Ref:** Standard 30 **Stated:** Second time	The registered manager of the home should review the current staffing arrangements with respect to the administration of medicines at night.	**Met**
	Action taken as confirmed during the inspection: Following discussion with staff it was found that this had been reviewed and designated staff were now trained or were in the process of completing training in all aspects of medicines management. They confirmed that trained staff were on duty at all times.	
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time	The registered manager should further develop the policies and procedures for medicines management and include standard operating procedures for controlled drugs.	**Met**
	Action taken as confirmed during the inspection: These policies were in place.	
Area for improvement 3 **Ref:** Standard 30 **Stated:** First time	The registered manager should ensure that an up to date list of the names, signatures and initials of all staff who are trained and deemed competent in medicines management is maintained.	**Met**
	Action taken as confirmed during the inspection: This list was provided at the inspection. The manager advised that the recently trained staff would be added to this list with immediate effect.	
Area for improvement 4 **Ref:** Standards 30 & 31 **Stated:** First time	The registered manager should review the management of distressed reactions to ensure care plans are developed and the parameters for administration are fully recorded on the personal medication record.	**Met**
	Action taken as confirmed during the inspection: A review of residents' records indicated that a care plan regarding distressed reactions was in place and this was used in conjunction with a restrictive intervention policy. Details of the medicine dosage were fully recorded on the residents' personal medication record.	

Area for improvement 5 **Ref:** Standard 30 & 31 **Stated:** First time	The registered manager should ensure that records are maintained which indicate that medicines which are administered via enteral feeding tubes are accompanied by flushes of water.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this had been reviewed following the last medicines management inspection; fluid intake charts detailed that the administration of medicines was accompanied by flushes of water. However, following a change in practice, the staff were no longer responsible for the administration of medicines, water or feeds via an enteral feeding tube. Community nurses were responsible for this.	

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.

Medicines were managed by staff who have been trained and deemed competent to do so. Staff complete training during one specific week per year, and to assist with this the residential care home is closed to admissions. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management and oxygen was provided in the last year. Training in dementia care was being provided to several staff during the inspection. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

Robust arrangements were in place for the management of medicines for residents at each period of respite care. Staff advised that having access to the resident's electronic care records has been beneficial in checking medicines at admission. They also advised of the procedures in place to manage any medicine changes during the resident's care in the home.

There were no controlled drugs which required safe custody at the time of the inspection. When held in stock, controlled drugs which require safe custody were checked at the end of each shift. A separate controlled drug record book was maintained for individual residents.

Appropriate arrangements were in place for administering medicines in disguised form. Staff confirmed that this practice was rarely required. A care plan was maintained and this included details of how individual medicines were to be administered. This is best practice.

Discontinued or expired medicines were disposed of appropriately. Any medicines remaining at the end of each respite care were returned to the family.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. A controlled drug cabinet and a medicines refrigerator were available for use when needed.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff, training, competency assessment, the management on medicines on admission/discharge and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	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 sample of medicines examined had been administered in accordance with the prescriber's instructions.

Epilepsy management plans were in place for the relevant residents.

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. A care plan was maintained. Staff advised that these medicines were rarely administered; however, when they were required, the reason for and the outcome of administration were recorded in the resident's notes.

The management of pain was reviewed. Staff advised that the administration of pain relief was rarely required. If it was required, then it was discussed with the relative or prescriber. The manager confirmed that staff would be aware of how the resident would express pain and that staff were very familiar with each resident's needs.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Details were also displayed in the kitchen area for staff. Each administration was recorded and care plans and speech and language assessment reports were in place. It was agreed that the prescribed consistency would also be recorded on the separate administration charts 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 family and/or prescriber.

Medicine records were well maintained and facilitated the audit process. The good standard of record keeping was acknowledged.

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

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

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

There were no medicines which required administration during the time of the inspection.

Following discussion with staff, it was confirmed that the residents were given as much time as needed to take their medicines and medicines were administered in accordance with their preferences. Details of these preferences were observed in the care plans examined at the inspection.

One resident was present in the home. It was not possible to obtain this resident's views and opinions of the home; however, she was found to be relaxed and comfortable in her surroundings and interactions with staff. She was enjoying some art activities.

Fifteen questionnaires were left in the home to facilitate feedback from residents, staff and relatives. Four were returned from staff and five from relatives, who advised that they were very satisfied/ satisfied with all aspects of the care in relation to the management of medicines.

Areas of good practice

Staff listened to residents and relatives 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. These had been updated since the last medicines inspection and some areas were being further developed. A group supervision session was held with all staff to ensure they were aware of and understood these new policies.

There were robust arrangements in place for the management of medicine related incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

An effective auditing system was in place. Medicines management was audited each week and all medicines were audited at the end of each period of respite care. This is good practice. Staff advised of the procedures which would be followed if a discrepancy or an area for improvement was identified.

The manager advised that following a review of the service and staff roles and responsibilities, additional staff will be trained in medicines management and therefore, there will no longer be any delegated tasks. From discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They advised that any medicine related concerns were raised with the manager.

We were advised that management were open and approachable and that there good working relationships within the home and with other healthcare professionals involved in resident care.

The areas for improvement identified at the last medicines management inspection had been addressed. The progress made was acknowledged.

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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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