Unannounced Medicines Management Inspection Report
25 February 2019

Malone

Type of service: Residential Care Home
Address: 188 Upper Malone Road, Belfast, BT17 9JZ
Tel No: 028 9061 1745
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 which provides care for up to 28 residents with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Malone Residential Home **Responsible Individual:** Mr Kevin McKinney	**Registered Manager:** Mrs Julie-Ann Russell
Person in charge at the time of inspection: Mrs Julie-Ann Russell	**Date manager registered:** 17 November 2015
Categories of care: Residential Care (RC): I – old age not falling within any other category DE – dementia PH – physical disability other than sensory impairment	**Number of registered places:** 28 This number includes: • a maximum of three persons accommodated in category RC-PH (under 65 years) • a maximum of 10 persons accommodated in category RC-DE

4.0 Inspection summary

An unannounced inspection took place on 25 February 2019 from 10.15 to 13.15.

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, the majority of medicine records, medicine storage and the management of controlled drugs.

One area for improvement was identified in relation to the standard of maintenance of the personal medication records.

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	1

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Julie-Ann Russell, Registered 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 2 May 2018. 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 QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection

During the inspection we met with four residents, one senior carer and the registered manager. We also spoke briefly with one care assistant and the domestic assistant.

We provided the registered manager with 10 questionnaires to distribute to residents and their representatives, for completion and return to RQIA. We left 'Have we missed you?' cards in the home to inform residents/their representatives, how to contact RQIA to tell us of their experience of the quality of care provided. Flyers providing details of how to raise concerns were also left in the home.

We asked the registered manager to display a poster which invited staff to share their views and opinions 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
- medicine audits
- care plans
- medicines storage temperatures
- controlled drug record book

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 registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 2 May 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was 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 15 June 2016

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: First time**	The registered provider must ensure that medicines are stored at the correct temperatures.	**Met**
	Action taken as confirmed during the inspection: This area for improvement referred to the temperature of the treatment room. A review of the daily temperature records indicated that the temperature was maintained at a maximum of 25^{o}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 registered manager advised that medicines were managed by senior carers who have been trained and deemed competent to do so. Training was updated annually. Competency assessments were completed following induction or more frequently if a need was identified.

The registered manager advised that she plans to complete competency assessments annually.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training was updated annually.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and to manage medication changes. Personal medication records and hand-written entries on the medication administration records were verified and signed by two trained staff. This safe practice was acknowledged.

There were systems in place to ensure that residents had a continuous supply of their prescribed medicines. There was evidence that antibiotics and newly prescribed medicines had been received into the home without delay.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Stock balance checks were performed on controlled drugs which require safe custody, at the end of each shift.

Satisfactory arrangements were in place for the safe disposal of discontinued or expired medicines.

The treatment room was small and in need of refurbishment. This was discussed with the registered manager who agreed to review. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The maximum, minimum and current refrigerator temperatures were monitored and recorded each day. Some temperatures outside the accepted range were observed. This was highlighted to the registered manager for ongoing vigilance.

Areas of good practice

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

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 majority of medicines examined had been administered in accordance with the prescriber's instructions. Apparent discrepancies in the administration of two medicines (one inhaled and one liquid) were discussed with the registered manager for close monitoring.

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 and monthly medicines were due.

Medicines for the management of distressed reactions were not prescribed for any residents.

The management of pain was discussed with both the registered manager and residents. All residents could verbalise their pain and advised that pain relief was provided promptly when requested. The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed.

The senior carer advised 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 discussed with the resident and reported to the prescriber.

The majority of medicine records were well maintained and facilitated the audit process. However, the following improvements were necessary in the standard of maintenance of the personal medication records:

- obsolete personal medication records should be cancelled and archived
- the allergy status of each resident should be recorded; 'none known' should be recorded where the allergy status is unknown
- the date of discontinuation of medicines should be recorded
- where medicines are administered by the community nursing team this should be highlighted

An area for improvement was identified.

Practices for the management of medicines were audited throughout the month by the senior carers. This included a daily audit of medicines which were not supplied in the blister pack. Monthly audits were also completed. A management audit was completed at approximately quarterly intervals.

Following discussion with the registered manager and senior carer, 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 most medicine records and the administration of medicines.

Areas for improvement

Arrangements should be made to ensure improvement in the standard of maintenance of the personal medication records.

	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.

The registered manager advised that some residents could self-administer their prescribed creams. It was agreed that when applicable this would be clearly detailed in a care plan and recorded on the personal medication records.

We observed the administration of medicines to a small number of residents during the morning round. The senior carer engaged the residents in conversation and explained that they were having 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 clear from discussion and observation of staff, that the staff were familiar with the residents' likes and dislikes. Residents were observed to be relaxed and comfortable.

We spoke with four residents who were complimentary regarding the care provided and staff in the home. Comments included:

- "The staff are great. They are very helpful."
- "I am as happy as I can be. The staff are good."
- "I am very happy here. I am not in any pain. I usually take paracetamol at night and I would ask for them if I needed them during the day."

As part of the inspection process, we issued 10 questionnaires to residents and their relatives/representatives. Six were returned and the responses indicated that relatives were 'satisfied' or 'very satisfied' with the care provided. Comments included:

"I am very satisfied and happy with the care my friend receives. She is made feel part of a large family surrounded by caring, friendly staff."
"We are well pleased with the care given – my aunt has been here almost a year and her health has improved greatly. The staff and surroundings are very pleasant and we would recommend it to anyone."

Any comments from residents and their representatives in questionnaires received after the return date (two weeks) will be shared with the registered manager for information and action as required.

Areas of good practice

Staff were observed to listen to residents, engage in conversation and respond to their requests.

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.

We discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents.

Written policies and procedures for the management of medicines were in place. The registered manager advised that they were due to be reviewed and updated.

Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence that action had been taken to ensure that disruptions to senior carers were minimised during the medicine rounds. In relation to the regional safeguarding procedures, the registered manager advised that staff were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were examined. Management advised of the auditing processes completed by both staff and management. Systems were in place to address any shortfalls.

Following discussion with the senior carer, it was evident that she was familiar with her role and responsibilities in relation to medicines management. She advised that any concerns in relation to medicines management were raised with the registered manager. She spoke positively about her work and the home.

We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date.

No online questionnaires were completed by staff within the specified time frame (two weeks).

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 Mrs Julie-Ann Russell, Registered 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 with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 25 March 2019	The registered person shall ensure that the necessary improvements to the personal medication records are implemented and sustained. Ref: 6.5
	Response by registered person detailing the actions taken: All improvements to the medication records have been implemented.

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

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