Unannounced Medicines Management Inspection Report
27 July 2016

Knockan Lodge

Type of Service: Residential Care Home
Address: 153 Finvoy Road, Ballymoney, BT53 7JN
Tel No: 028 2957 1540
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Knockan Lodge took place on 27 July 2016 from 09:30 to 12:30.

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?

The management of medicines supported the delivery of safe care. 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. There were no areas of improvement identified.

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. However, recommendations were made regarding reviewing the arrangements for recording medicines prescribed on a "when required" basis for the management of distressed reactions and the recording of the consistency of food and fluid thickening agents.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely. Residents consulted with confirmed that they were administered their medicines appropriately. There were no areas of improvement identified.

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. There were no areas of improvement identified.

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	2

Details of the QIP within this report were discussed with Ms Marie Jamison, Care 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

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the previous QIP, there were no further actions required to be taken following the last inspection on 5 July 2016.

2.0 Service details

Registered organisation/ registered provider: Knockan Lodge/ Mr P J Doherty	**Registered manager:** Ms Anna May Elder
Person in charge of the home at the time of inspection: Ms Marie Jamison (Care Manager)	**Date manager registered:** 1 April 2005.
Categories of care: RC-I, RC-MP(E), RC-PH(E), RC-DE	**Number of registered places:** 25

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home

Prior to the inspection, it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

A poster indicating that the inspection was taking place was displayed on the front door of the home. The poster invited visitors/ relatives to speak with the inspector. On this occasion, no-one availed of this opportunity.

During the inspection the inspector met with three residents, the care manager and a senior care assistant.

The following records were 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 5 July 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be reviewed by the care inspector following its return to RQIA. This QIP will be validated by the care inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 16 April 2013

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The registered manager must ensure that records of training and competency are maintained for designated care staff responsible for medicine related tasks.	**Met**
	Action taken as confirmed during the inspection: Records of training and competency were maintained for designated care staff responsible for medicine related tasks.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 30 **Stated:** Second time	The registered manager should develop and implement written Standard Operating Procedures for controlled drugs specific to Knockan Lodge.	**Met**
	Action taken as confirmed during the inspection: Standard Operating Procedures had been developed detailing the arrangements for the management of controlled drugs.	

Recommendation 2 **Ref**: Standard 31 **Stated:** First time	The registered manager should ensure that the member of staff signing/initialling entries on medication administration records uses their own signature/initials in order to identify them.	**Met**
	Action taken as confirmed during the inspection: Members of staff signing/initialling entries on medication administration records had used their own signature/initials.	

4.3 Is care safe?

Medicines were managed by staff who had been trained and deemed competent to do so. An induction process was in place. The impact of training was monitored through team meetings, supervision and annual appraisal. The most recent medicines management training was provided to staff by the registered manager in March 2016. Competency assessments were completed every six months and were up-to-date.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Procedures were in place to identify and report any potential shortfalls in medicines. Robust arrangements were in place for ensuring supplies of acute prescriptions such as antibiotics were obtained and administered in a timely fashion.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medicine administration 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 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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts for warfarin was acknowledged.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturers' 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.

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 and 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, 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. However, a care plan was not maintained and the reason and effect of administration were not recorded; 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 pain was assessed as part of the admission process. A care plan was maintained when a resident required analgesia on a regular basis.

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 generally well maintained and facilitated the audit process. However, for one resident, the thickening agent consistency was not recorded in their personal medication record or care plan; a recommendation was made.

Practices for the management of medicines were audited throughout the month by the staff and management.

Following discussion with the staff, it was evident that they had good working relationships with other healthcare workers, including the community pharmacists, prescribers and community nursing services.

Areas for improvement

The arrangements for the recording of medicines prescribed on a "when required" basis for the management of distressed reactions should be reviewed. A recommendation was made.

The thickening agent consistency should be routinely recorded in the resident's personal medication record and care plan. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

The administration of medicines to several residents was observed during the inspection. Medicines were administered to residents in the dining room. The staff member administering the medicines spoke to the residents in a kind and caring manner and the residents were given time to swallow each medicine. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

The residents spoken to advised that they had no concerns in relation to the management of their medicines. They each spoke very positively about the care they received.

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 knowledgeable of the policies and procedures and that any updates were highlighted to them.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents.

A review of the audit records indicated that satisfactory outcomes had been achieved.

Following discussion with the care staff, it was evident that they 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.

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

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Marie Jamison, Care Manager 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 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 may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to *RQIA's* office for review 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	
Recommendations	
Recommendation 1 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 26 August 2016	The registered provider should ensure that the arrangements for the recording of medicines prescribed on a "when required" basis for the management of distressed reactions are reviewed. **Response by registered provider detailing the actions taken:** These have all now been reviewed and a seperate sheet added to the residents care plan to show this Medication has been prescribed by the GP.
Recommendation 2 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 26 August 2016	The registered provider should ensure that the thickening agent consistency is routinely recorded in the resident's personal medication record and care plan. **Response by registered provider detailing the actions taken:** The residents personal care plan and Medication record has now been updated to show what stage the thickening agent is used and recorded as such on Mars sheets -

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