Unannounced Medicines Management Inspection Report
1 October 2018

Knockan Lodge

Type of service: Residential Care Home
Address: 153 Finvoy Road, Ballymoney, BT53 7JN
Tel No: 028 2957 1540
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 25 beds that provides care for residents living with care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Knockan Lodge **Responsible Individual:** Mr P J Doherty	**Registered Manager:** Ms Anna May Elder
Person in charge at the time of inspection: Ms Tracey Woods, Senior Care Assistant	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) DE - Dementia I - Old age not falling within any other category MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 25

4.0 Inspection summary

An unannounced inspection took place on 1 October 2018 from 10.15 to 13.50.

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.

There were some examples of good practice in relation to the completion of medicine records, the administration of the majority of medicines, the management of controlled drugs and the storage arrangements for medicines.

Areas for improvement were identified in relation to the management of new resident's medicines and medicine changes, management of warfarin, care planning, and administration of bisphosphonates, photographs and audit.

Residents said they were happy in the home and spoke positively about the management of their medicines and the care provided by staff. We noted the warm and welcoming atmosphere 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	2	*7

The total number of areas for improvement includes one which have been stated for a second time and one which has been carried forward for review at the next medicines management inspection.

Details of the Quality Improvement Plan (QIP) were discussed with Ms Tracey Woods, Senior Care Assistant and with Mr P J Doherty, Registered Provider, by telephone on 2 October 2018, 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

Other than those actions detailed in the QIP no further actions were required to be taken following the care inspection undertaken on 27 June 2018. 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 was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

During the inspection we met with three residents, one member of care staff and the person in charge.

We provided 10 questionnaires to distribute to residents and their representatives, for completion and return to RQIA and we asked the person in charge 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 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

We left 'Have we missed you?' cards in the home to inform residents and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

One of the areas for improvement identified at the last medicines management inspection was reviewed and the assessment of compliance recorded; and one area for improvement which was not examined has been carried forward for examination at the next medicine management inspection.

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 27 June 2018

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 27 July 2016

Areas for improvement from the last medicines management inspection		
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 6 **Stated:** First time	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.	**Not met**
	Action taken as confirmed during the inspection: There was limited evidence to indicate that the management of distressed reactions had been reviewed. Detailed care plans were not maintained, regular use was not referred to the prescriber and the outcome of administration was not recorded. This area for improvement has been stated for a second time.	

Area for Improvement 2 **Ref**: Standard 31 **Stated:** First time	The registered provider should ensure that the thickening agent consistency is routinely recorded in the resident's personal medication record and care plan.	**Carried forward to the next medicines management inspection**
	Action taken as confirmed during the inspection: Thickening agents were not prescribed for any residents at the time of this inspection. This area for improvement will be assessed at the next medicines management inspection.	

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 completed a competency assessment following induction and at least annually. The person in charge advised that the impact of training was monitored through team meetings, six monthly supervision and appraisal. A sample of records was provided. Refresher training in medicines management had been provided in March 2018. In relation to safeguarding, staff were aware of the regional procedures and who to report any safeguarding concerns to.

The management of new resident's medicines was examined. Written confirmation of the resident's medicine regime was not obtained or verified at the time of admission. This was discussed in relation to the safe management of medicines. An area for improvement 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, report and follow up any potential shortfalls in medicines. Newly prescribed medicines had been received into the home without delay.

In relation to high risk medicines such as warfarin, written confirmation of the dosage regime was not obtained, and two staff were not involved in receiving the telephoned directions or transcribing the dosage regime. The process for the safe management of warfarin was discussed with reference to RQIA guidance published on our website. An area for improvement was identified.

The management of medicine changes was reviewed. These were recorded on the personal medication records by one member of staff. This should involve two members of staff to ensure accuracy in the transcribing. An area for improvement was identified.

Robust arrangements were in place for the management of controlled drugs. Additional stock checks were performed on controlled drugs which do not require storage in a controlled drug cabinet. This good practice was acknowledged.

Community nurses were responsible for the administration of insulin. Staff confirmed that they were familiar with the signs and symptoms of changes in blood sugar levels.

Discontinued or expired medicines including controlled drugs were returned to the community pharmacy for disposal.

Most of the medicines were stored safely and securely and in accordance with the manufacturer's instructions. Staff were reminded that sachets of lidocaine plasters must be kept sealed.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment and the management of controlled drugs.

Areas for improvement

Written confirmation of medicine regimes at the time of admission should be obtained.

The management of warfarin must be reviewed to ensure that robust arrangements are in place.

Any transcribing on medicine records should involve two members of trained staff; both staff should initial the entry.

	Regulations	Standards
Total number of areas for improvement	1	2

6.5 Is care effective?

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

The majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. However, we noted a number of discrepancies in medicines and these were highlighted for close monitoring. See also Section 6.7. In addition, the audit outcomes indicated that two bisphosphonate medicines had not been administered at weekly intervals as prescribed; in each case an extra dose had been administered. An area for improvement was identified. It was agreed that this would be referred to the prescriber immediately after the inspection.

The care planning in relation to medicines management was reviewed. Following discussion and observation of care files, detailed care plans for the management of distressed reactions, pain management, warfarin and insulin were not in place. An area for improvement was identified.

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 all of the residents could verbalise any pain.

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. We were advised that 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, we noted that some residents were being administered these medicines every day; there was no evidence that that the increase in use had been recognised or had been referred to the prescriber. Details of the reason for and outcome of the administration were not routinely recorded. This was discussed with reference to RQIA guidance published on our website. See also Section 6.2. This area for improvement has been stated for a second time.

Staff confirmed that medicine omissions or refusals likely to have an adverse effect on the resident's health were reported to the prescriber.

We reviewed several medicine records. Some of these were well maintained and facilitated the audit process e.g. personal medication records and receipt of medicines records. The personal medication records were written and signed by two members of staff. However, the resident's photograph was not attached/located with their personal medication record and we established that only some of the care files included the resident's photograph; these should be in place for the safe administration of medicines. An area for improvement was identified.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the person in charge, it was evident that when applicable, other healthcare professionals were contacted in response to resident's needs.

Areas of good practice

There were examples of good practice in relation to the completion of some medicine records and administration of most medicines.

Areas for improvement

Robust arrangements must be developed for the management of bisphosphonate medicines.

The care planning in relation to medicines management should be reviewed to ensure the care plans are reflective of the resident's needs.

One area for improvement in relation to distressed reactions has been stated for a second time.

The resident's photograph should be attached/located with their personal medication record.

	Regulations	Standards
Total number of areas for improvement	1	2

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 administration of medicines to residents was not observed during the inspection.

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 observation of staff, that they were familiar with the residents' likes and dislikes.

We met with three residents, who expressed satisfaction with the staff and the care provided. They advised they were administered their medicines on time and any requests for e.g. pain relief were met. They stated they had no concerns. Comments included:

- "I am happy enough here."
- "The staff are good."
- "The food is ok, I get what I like."
- "I couldn't say anything bad at all; I've nothing to complain about."

Of the questionnaires which were left in the home to facilitate feedback from residents and their representatives, none were returned within the time frame (two weeks). Any comments in questionnaires received after the return date will be shared with the registered manager as necessary.

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.

The inspector 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. Staff confirmed there were arrangements in place to implement the collection of equality data within Knockan Lodge.

Written policies and procedures for the management of medicines were in place. We were advised that these were reviewed every few years.

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

The governance arrangements for medicines management were reviewed. Staff advised of the auditing processes and oversight by the registered manager. A review of the audit records indicated that largely satisfactory outcomes had been achieved. However, as areas for improvement were identified in the domains of safe and effective care and one area for improvement had not been satisfactorily addressed, the current auditing processes should be reviewed. An area for improvement was identified. It was suggested that the QIP is used as part of the auditing process to ensure sustained improvement.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with the registered manager.

The staff we met with spoke positively about their work and advised there were good working relationships in the home with staff and the registered manager. 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 clearly defined roles and responsibilities for staff.

Areas for improvement

The auditing arrangements for medicines management should be reviewed to ensure that they are effective.

	Regulations	Standards
Total number of areas for improvement	0	1

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 Ms Tracey Woods, Senior Care Assistant, and Mr P J Doherty, Registered Provider, 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 1 November 2018	The registered person shall develop robust arrangements for the management of warfarin. Ref: 6.4
	Response by registered person detailing the actions taken: Warfarin record sheet and separate warfarin medicine sheet in situ. Daily countin warfarin folder and updated in care plan. INR telephone results are taken by 2 members of staff, recorded and signed and countersigned in inr kardex. Telephone is put on loudspeaker for this purpose.
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 1 November 2018	The registered person shall review the management of bisphosphonate medicines to ensure these are administered as prescribed. Ref: 6.5
	Response by registered person detailing the actions taken: This has been reviewed and updated. Staff made aware of instruction on on medicine kardex and origional packaging regarding medication.
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:** 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. Ref: 6.2
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next medicines management inspection.

Area for improvement 2 **Ref**: Standard 6 **Stated:** Second time **To be completed by:** 1 November 2018	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. Ref: 6.2 & 6.4
	Response by registered person detailing the actions taken: When required' medicines are recorded in medicine kardex and in daily notes. Book in situ for 'when required' medicines. If this becomes regular occourance then a refferal is made to GP for review of medicine.
Area for improvement 3 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 1 November 2018	The registered person shall ensure that written confirmation of medicine regimes is obtained for new residents. Ref: 6.4
	Response by registered person detailing the actions taken: confirmation in writing is obtained for each resident.
Area for improvement 4 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 1 November 2018	The registered person shall ensure that two staff are involved in transcribing medicines information onto medicine records. Ref: 6.4
	Response by registered person detailing the actions taken: Two staff transcribe medicines to medicine record and sign and countersign.
Area for improvement 5 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 1 November 2018	The registered person shall ensure that care plans are updated in relation to medicines management to reflect the resident’s needs. Ref: 6.5
	Response by registered person detailing the actions taken: Care plans are updated individually and copy of daily kardex filed in each care plan and updated when any change of medication.
Area for improvement 6 **Ref**: Standard 8 **Stated:** First time **To be completed by:** 1 November 2018	The registered person should ensure that a photograph of the resident is available for the safe administration of medicines, as detailed in the report. Ref: 6.5
	Response by registered person detailing the actions taken: Photographs of all residents taken and in process.

Area for improvement 7 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 1 November 2018	The registered person should further develop the auditing process for medicines management to ensure that it is effective. Ref: 6.7
	Response by registered person detailing the actions taken: Auditing process for medicine management is done on weekly and monthly and also random checks

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

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