Unannounced Medicines Management Inspection Report
6 April 2016

Victoria House

22 Moneyleck Road, Rasharkin, BT44 8QB
Tel No: 028 2957 1423
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Victoria House took place on 6 April 2016 from 09.50 to 12.45.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

Is care safe?

One recommendation has been made.

Is care effective?

Two recommendations have been made.

Is care compassionate?

No requirements or recommendations have been made.

Is the service well led?

No requirements or recommendations have been made.

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	3

Details of the QIP within this report were discussed with the Assistant Manager, Mrs Rhonda Henry, 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 most recent inspection on 1 March 2016.

2.0 Service details

Registered organisation/registered person: Mr Samuel Derek Robinson Wallace	**Registered manager:** Mr Samuel Derek Robinson Wallace
Person in charge of the home at the time of inspection: Mrs Rhonda Henry (Assistant Manager)	**Date manager registered:** 1 April 2005
Categories of care: RC-I, RC-LD, RC-DE	**Number of registered places:** 11

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned quality improvement plans
- 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.

We also met with two residents, one member of care staff, and briefly with the registered manager.

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 1 March 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 28 May 2013

There were no requirements made as a result of the last medicines management inspection.

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 & 31 **Stated:** Second time	Two members of staff should be involved in recording new medicine details onto the personal medication record.	**Met**
	Action taken as confirmed during the inspection: All personal medication records included two staff signatures verifying the accuracy of transcription. The majority of new entries were also verified by two members of staff and staff confirmed that this is the usual procedure. It was discussed and agreed that this safe practice would continue.	
Recommendation 2 **Ref**: Standard 30 **Stated:** First time	Standard Operating Procedures for the management of controlled drugs, specific to Victoria House, should be developed and implemented.	**Met**
	Action taken as confirmed during the inspection: These were available within the policy and procedure documents for the management of medicines. It was discussed and agreed that these should be reviewed and revised as necessary on a regular basis.	

Recommendation 3 **Ref**: Standard 31 **Stated:** First time	The date of writing should be recorded on all personal medication records for archiving purposes.	**Met**
	Action taken as confirmed during the inspection: The date of writing was recorded on all personal medication records.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings; however no formal records of competency assessment or of supervision and appraisal were maintained. A recommendation 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 and report any potential shortfalls in medicines.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were mostly updated by two members of staff. Ensuring this safe practice takes place on every occasion was discussed and agreed.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home 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.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturer's 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. Suitable arrangements were in place for the management of medicines which required cold storage.

Areas for improvement

Records of competency assessment in the management of medicines and of supervision and appraisal should be maintained for all designated staff. A recommendation was made.

Number of requirements	**0**	**Number of recommendations**	**1**

4.4 Is care effective?

The sample of medicines examined had mostly been administered in accordance with the prescriber's instructions. Discrepancies were identified in some inhaled medicines, this was discussed and the assistant manager agreed to investigate and to monitor the administration of these medicines. 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, monthly or 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. The reason for and the outcome of each administration were not always recorded. A recommendation was made. A care plan was in place however these should be developed further and be specific to the resident. A recommendation regarding care plans 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 most of the residents could verbalise any pain, and a pain tool was used as needed. Pain is assessed as part of the admission process. However, a care plan for the management of pain, specific to the resident was not maintained. A recommendation was made.

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. Areas of good practice were acknowledged. They included recording the date of opening on all medicines and on the personal medication record. Insulin was not always recorded on the personal medication record as it is administered by community nurses; it was discussed and agreed that it would be included to ensure that the personal medication record is a complete record of all prescribed medicines.

Practices for the management of medicines were audited monthly by the staff and the assistant manager. In addition, a quarterly audit was completed by the community pharmacist. These audits had resulted in positive outcomes.

It was evident that when applicable, other healthcare professionals were contacted regarding the management of medicines.

Areas for improvement

The reason for and the outcome of administration of medicines prescribed for use "when required" for distressed reactions should be recorded on every occasion. A recommendation was made.

Care plans should be further developed to include the management of pain and distressed reactions specific to the resident. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

The administration of medicines to residents was completed in a caring manner, residents were given time to take their medicines and medicines were administered as discreetly as possible.

Two residents advised that they were very satisfied with the manner in which their medicines were managed and administered.

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. Management advised that these were reviewed as necessary. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

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

A review of the audit records indicated that satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the assistant manager and care staff, it was evident that staff 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 the assistant manager.

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 the Assistant Manager, Mrs Rhonda Henry, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. 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 registered person/s 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 DHSSPS Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to **pharmacists@rqia.org.uk** and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the service. The findings set out are only 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 person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager 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 30 **Stated:** First time **To be completed by:** 6 May 2016	Records of competency assessment and of supervision and appraisal should be maintained for all staff involved in the management of medicines. **Response by registered person detailing the actions taken:** This has been done for all staff who administer medication.
Recommendation 2 **Ref**: Standard 10 **Stated:** First time **To be completed by:** 6 May 2016	The reason for and the outcome of the administration of medicines prescribed for use “when required” for distressed reactions should be recorded on every occasion. **Response by registered person detailing the actions taken:** This is in operation now once all staff were notified on the change.
Recommendation 3 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 6 May 2016	Care plans should be further developed to include the management of pain and distressed reactions specific to the resident. **Response by registered person detailing the actions taken:** This also hasd been done in all relevant Care Plans.

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