Unannounced Medicines Management Inspection Report
23 August 2016

Redford

Type of service: Residential Care Home
Address: 15 Redford Road, Cullybackey, BT43 5PR
Tel No: 028 2588 0671
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Redford took place on 23 August 2016 from 10.35 to 13.50.

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?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for residents. 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. No requirements or recommendations were made.

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. Two areas of improvement was identified in relation to care plans and two recommendations were made. No requirements were made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for residents. 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. There were robust systems to manage and share the learning from medicine related incidents and areas identified within the audit process. No requirements or recommendations were 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	2

Details of the QIP within this report were discussed with Ms Perdita Kerr, Assistant Manager, a member of senior care staff and Mr Trevor Gillen, 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

1.2 Actions/enforcement taken following the most recent premises inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 26 July 2016.

2.0 Service details

Registered organisation/ registered provider: Mr William James Wallace	**Registered manager:** Mr Trevor Gillen
Person in charge of the home at the time of inspection: Ms Perdita Kerr, Assistant Manager	**Date manager registered:** 21 November 2013
Categories of care: RC-DE, RC-I, RC-PH(E)	**Number of registered places:** 18

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection.

During the inspection, the inspector met with one resident, two members of senior care staff, the assistant manager and the registered manager.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

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
- medicines storage temperatures
- medicine audits
- policies and procedures
- care plans
- training records

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 26 July 2016

The most recent inspection of the home was an announced premises inspection. The report has been issued to the home. The completed QIP will be reviewed by the estates inspector and will be validated by the estates inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 1 April 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** Second time	The registered manager must review the management of personal medication records to ensure that: • robust systems are in place to manage any changes in medicine dosages. Entries on personal medication records must not be amended • obsolete/discontinued personal medication records are removed, discontinued appropriately and securely archived.	**Met**
	Action taken as confirmed during the inspection: Satisfactory arrangements for the management of personal medication records were evidenced at the inspection.	
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure that written confirmation of medicine regimes is obtained for all new residents.	**Met**
	Action taken as confirmed during the inspection: There was evidence that written confirmation of medicine regimes was obtained for new residents and also when a resident is readmitted to the home.	

Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must review the stock control of medicines to ensure that all medicines are available for administration as prescribed and any shortfalls in medicines supplies are readily identified and obtained in a timely manner.	**Met**
	Action taken as confirmed during the inspection: A system is in place to check stock levels and dates of expiry and replace stock. There was no evidence that any medicines had been omitted due to being out of stock.	
Requirement 4 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must ensure there are robust arrangements in place for the cold storage of medicines; these arrangements must be detailed in the home's policies and procedures.	**Met**
	Action taken as confirmed during the inspection: Improvements were noted in the management of medicines which require cold storage. Daily refrigerator temperature checks were recorded and were within the accepted range. Some ice had formed and it was agreed that the medicines refrigerator would be defrosted later on the day of the inspection. A policy regarding the cold storage of medicines was in place.	
Requirement 5 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must forward copies of the records of the medicine refrigerator temperatures for the months of April and May 2014.	**Met**
	Action taken as confirmed during the inspection: These temperature records were forwarded to RQIA within the specified timescales.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	The registered manager should develop and implement written standard operating procedures for controlled drugs.	**Met**
	Action taken as confirmed during the inspection: These procedures had been developed and a date of the next review was recorded.	

Recommendation 2 **Ref**: Standard 31 **Stated:** First time	The registered manager should ensure that two trained staff are involved in the transcribing of medicines information on personal medication records, medication administration records and warfarin administration records; both staff should initial the record.	**Met**
	Action taken as confirmed during the inspection: There was evidence that two members of staff were routinely involved in the transcribing of medicines information on medicine 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, supervision and annual appraisal. Competency assessments were completed annually and more frequently if required. Refresher training in medicines management was provided in the last year.

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 and handwritten entries on medication 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 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. Medicine refrigerators were checked at regular intervals. Some ice had formed in the medicines refrigerator and it was agreed that the medicine refrigerator would be defrosted later on the day of the inspection.

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 alternate day and weekly medicines were due.

Of the care plans examined, it was noted that two care plans were not accurate. This was discussed with management and the need to ensure that these were up to date was emphasised. Management confirmed by email on 25 August 2016 that these care plans had been revised and were up to date. A system to ensure that care plans are accurately maintained at all times should be developed; a recommendation was made.

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. The reason for and the outcome of administration were recorded. A care plan was maintained.

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 the residents could verbalise any pain. Staff also advised that a pain assessment was completed as part of the admission process. A care plan was not maintained. This should be reviewed and 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 separate records for the administration of transdermal patches. However, it was noted that during this medicine cycle there had been some missing signatures for administration. Whilst the audit indicated that the medicine had been administered, staff should ensure that records of administration are maintained on every occasion. This was discussed and it was agreed that this would be raised with staff.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines. In addition, a quarterly audit was completed by the community pharmacist. The good practice of recording the quantity of medicine carried forward into the next medicine cycle and recording the date of opening on medicines was acknowledged; this readily facilitated the audit process.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to medicine related issue/concerns. A separate area in the care plan folder is maintained to record this information.

Areas for improvement

A robust system should be developed to ensure that the information detailed in care plans is up to date. A recommendation was made.

The management of pain should be reviewed to ensure that where medicines are prescribed to manage pain, this is referenced in a care plan. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

The administration of medicines to residents was not observed at the time of the inspection. Following discussion with staff, it was found that medicines were administered on time, in accordance with the residents' preferences and residents were given time to take their medicines.

The resident spoken to at the inspection had no concerns regarding the management of their medicines and was content with the care provided by staff. The resident spoke positively about the staff and advised that staff responded in a timely manner to any requests for medicines e.g. pain relief.

Residents who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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. These were reviewed every three years. 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 largely satisfactory arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. However, it was found that one recent incident had occurred; this had been followed up with the prescriber; there was no evidence that this had been shared with management or reported to RQIA. It was concluded that this was an oversight and the registered manager advised that he would look into this issue and also address with staff. Written details regarding this incident were forwarded to RQIA after the inspection.

A review of the internal audit records indicated that largely 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. As part of best practice, it was

suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Following discussion with the registered 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 management. They advised that any resultant action was communicated at handover, individually and at team meetings.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Perdita Kerr, Assistant Manager, a member of senior care staff and Mr Trevor Gillen, Registered 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 registered provider 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 registered provider/manager 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 and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to *pharmacists@rqia.org.uk* for assessment 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:** 28 September 2016	The registered provider should develop a system to ensure that the information in care plans is up to date.
	Response by registered provider detailing the actions taken: All senior staff have been advised that information on care plans must be kept up to date. Care plans will be audited on a monthly basis my management staff.
Recommendation 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 28 September 2016	The registered provider should ensure that where medicines are prescribed for the management of pain, this is referenced in a care plan.
	Response by registered provider detailing the actions taken: Senior staff have been advised that all medication prescribed for pain management should be referenced in the care plan.

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address

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