Unannounced Medicines Management Inspection Report
25 May 2017

Seabank

Type of service: Residential Care Home
Address: 12a Bath Terrace, Portrush, BT56 8AN
Tel No: 028 7082 4285
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Seabank took place on 25 May 2017 from 10.30 to 13.30.

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?

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 mostly satisfactory systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. One area for improvement was identified in relation to new entries on personal medication records and a recommendation was 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. There were no areas for improvement identified.

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 for 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 for 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	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Dawn Fullerton, 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 care inspection

Other than the action detailed in the QIP there were no further actions required to be taken following the most recent inspection on 25 April 2017.

2.0 Service details

Registered organisation/registered person: Seabank Private Residential Home Mr William Alexander Duncan & Mr Ian McClure (registration pending)	**Registered manager:** Mrs Dawn Fullerton
Person in charge of the home at the time of inspection: Mrs Dawn Fullerton	**Date manager registered:** 26 August 2008
Categories of care: RC-PH, RC-MP, RC-DE, RC-I, RC-MP(E), RC-PH(E)	**Number of registered places:** 37

3.0 Methods/processes

Prior to the inspection the following records were analysed:

- 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

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.

We spoke to three residents and met with the registered manager, one senior care assistant, two visiting professionals and the local mayor.

Fifteen questionnaires were issued to residents, residents' relatives/representatives and staff, with a request that these were completed and returned to RQIA within one week of 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
- 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 25 April 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and will be reviewed by the care inspector. 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 4 August 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 31 **Stated:** First time	It is recommended that the registered person ensures records of administration of external medicines are accurately maintained at all times.	**Met**
	Action taken as confirmed during the inspection: A separate personal medication record and medication administration record are now maintained for these preparations. The majority of those examined were prescribed on a 'when required' basis. Records of administration had improved and the registered manager agreed that these would be checked within audit procedures to ensure that records are completed accurately.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was provided for all relevant care staff in April 2016. Training in the management of diabetes and insulin administration had been provided by the diabetes specialist nurse.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. The registered manager advised of the procedures to identify and report any potential shortfalls in medicines. There were safe systems in place for obtaining and storing any prescriptions until they were dispensed.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. However, new entries on personal medication records should be checked for accuracy and signed by two competent members of staff. A recommendation was made.

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.

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

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. The medicine refrigerator was checked at regular intervals.

Areas for improvement

New entries on personal medication records should be checked for accuracy and signed by two competent members of staff. A recommendation was made.

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

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 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, 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 usually recorded, staff were reminded to record this detail on every occasion. 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. The registered manager advised that for those residents who could not verbalise any pain, staff knew how the residents would express pain.

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.

Practices for the management of medicines were audited regularly and good outcomes had been recorded. In addition, a regular audit was completed by the community pharmacist.

Following discussion with the staff, it was evident that when applicable, other healthcare professionals were contacted in response to matters relating to medicines management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

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.

We met with three residents who were complimentary about their care and the management of medicines within the home. 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.

We met with two visiting professionals (a community nurse and the community pharmacist) who were also complimentary about the staff and the care provided by the home.

There was a good atmosphere in the lounges and entrance to the home. Several residents were outside enjoying the sunny day and the local mayor was visiting and chatting to staff and residents.

As part of the inspection process, questionnaires were issued to residents, relatives/residents' representatives and staff. Three questionnaires were returned by staff, three by relatives and four by residents within the specified timescale. Responses indicated that those who replied were satisfied or very satisfied with the management of medicines in the home.

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 had been reviewed and revised in January 2017. The registered manager confirmed that any updates were highlighted to staff.

There were robust arrangements in place for the management of medicine related incidents. The manager confirmed that all relevant staff knew how to identify and report incidents. One medicine related incident reported since the last medicines management inspection was discussed.

Following discussion with staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. The registered manager confirmed that staff had received training on adult safeguarding and were aware that medication incidents may need to be reported to the adult safeguarding lead.

A review of the audit records indicated that satisfactory outcomes had been achieved. The registered manager advised of the procedures in place to ensure that appropriate action was taken should a discrepancy arise.

Staff confirmed that any concerns in relation to medicines management were raised with management and that outcomes were shared with staff.

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 Mrs Dawn Fullerton, 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 to be 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 31 **Stated:** First time **To be completed by:** 25 June 2017	The registered provider should ensure that new entries on personal medication records are checked for accuracy and signed by two competent members of staff. **Response by registered provider detailing the actions taken:** This recommendation has been fully implemented

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

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