Unannounced Medicines Management Inspection Report
9 May 2017

Karingmore

Type of service: Residential Care Home
Address: 19 Largy Road, Carnlough, BT44 0EY
Tel No: 028 2888 5568
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Karingmore took place on 9 May 2017 from 10.20 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 largely satisfactory systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. One area was identified for improvement in relation to medicine changes. One recommendation was made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure that residents were receiving their medicines as prescribed. Care plans in relation to specific areas of medicines management were in place. Two areas of improvement were identified in relation to the administration of medicines and distressed reactions. Two recommendations 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. No requirements or recommendations were made.

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. 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	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Mary Theresa Hamill, Registered Manager and the senior care assistant on duty, 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 QIP there were no further actions required to be taken following the most recent inspection on 25 January 2017.

2.0 Service details

Registered organisation/registered person: Mr Liam Hamill & Mrs Mary Theresa Hamill	**Registered Manager:** Mrs Mary Theresa Hamill
Person in charge of the home at the time of inspection: Mrs Mary Theresa Hamill	**Date Manager Registered:** 1 April 2005
Categories of care: RC-DE, RC-I, RC-LD(E)	**Number of registered places:** 16

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the incidents register - it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

We met with one resident, one member of senior care staff 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.

Fifteen questionnaires were issued to residents, their relatives/representatives and staff, with a request that these were completed and returned 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 January 2017

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.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 8 June 2015

Last medicines management inspection statutory requirements		**Validation of compliance**
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must closely monitor the administration of liquid medicines and inhaled medicines. Any further discrepancies must be investigated and reported to RQIA.	**Met**
	Action taken as confirmed during the inspection: The completed QIP indicated that these medicines had been closely monitored at that time. There was evidence that liquid medicines were routinely audited every month. Occasional audits were performed on inhaled medicines.	
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.	**Met**
	Action taken as confirmed during the inspection: Whilst it was acknowledged that controlled drugs were being managed within safe practice, and there was evidence that the procedures for the management of controlled drugs had been marked as reviewed earlier this year, these did not reflect the current practices in the home and required further detail. This was discussed with the registered manager who advised this would be addressed. **Given the assurances provided and the systems in place, this recommendation has been assessed as met.**	

Recommendation 2 **Ref**: Standard 30 **Stated:** First time	It is recommended that the registered person should review the management of medicines which are administered in disguised form to ensure that a written policy and procedure is in place and a care plan is developed for the relevant resident(s).	**Met**
	Action taken as confirmed during the inspection: The completed QIP indicated that this had been addressed following the last medicines management inspection. A written policy and procedure had been developed and implemented. There were no residents who required the administration of medicines in disguised form at the time of the inspection.	
Recommendation 3 **Ref**: Standard 30 **Stated**: First time	It is recommended that the registered person should review the management of distressed reactions to ensure that a care plan is developed, the parameters for administration are detailed and the reason for and outcome of the administration are recorded on every occasion.	**Partially Met**
	Action taken as confirmed during the inspection: There was evidence that a care plan regarding the management of distressed reactions was in place. For one resident there was regular administration. The reason and outcome of the administration was not recorded. This should be recorded on each occasion and any regular administration should be referred to the prescriber. **An element of this recommendation is stated for a second time**.	
Recommendation 4 **Ref**: Standard 30 **Stated**: First time	It is recommended that the registered person should review the management of pain, to ensure that a pain assessment is completed for all new residents; and a care plan is developed for those residents who are prescribed medicines on a "when required" basis to treat or prevent pain.	**Met**
	Action taken as confirmed during the inspection: There was evidence that pain was referenced in the residents care plan and also a 'Patient Comfort Assessment Guide" was maintained. This assessment tool detailed the areas of pain, how it would be expressed by the resident, the level of pain and the medicines prescribed for pain.	

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 supervision and annual appraisal. Competency assessments were completed annually. A sample of training records was provided at the inspection. Refresher training in the management of medicines, safeguarding, dysphagia, external preparations and warfarin had been 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. Suitable arrangements were in place for the receipt and safe storage of prescription forms.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. Antibiotics and new medicines had been received and commenced in a timely manner. However, updates to the resident's personal medication records were not signed and verified by two members of staff. This should be addressed to ensure safe practice. 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 relation to one Schedule 2 controlled drug, the record book pages should be numbered and indicate the time of administration. Advice was given. It was agreed that the registered manager would raise this with staff and develop a new record layout to include this information. Checks were performed on all controlled drugs held in stock, at the end of each shift. The daily checks on Schedule 4 controlled drugs were 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

Any updates to the personal medication records should be signed and verified by two staff. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

Most of the medicines examined had been administered in accordance with the prescriber's instructions. A few audit trails could not be concluded as the date of opening was not recorded. Staff confirmed that this was the expected practice and was an oversight.

For two residents, it was found that two medicines were not being administered as prescribed. This was discussed in detail and staff advised that one resident preferred to reduce the dose of the medicine and the other resident had decided not to take the medicine. Whilst it was acknowledged that the residents had capacity to make these choices and staff were adhering to their wishes, the need to ensure that the prescriber was informed was emphasised. A recommendation was made.

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 injections were due to be administered by community nurses.

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. A care plan was maintained. 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. For one resident the medicine was administered every morning. The reason for and the outcome of administration were not recorded; however, staff were able to provide an explanation for the regular administration. Any regular administration should be referred to the prescriber (see also Section 4.2). Part of the recommendation was stated for a second time.

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 assessment tool was used as needed. A care plan was maintained.

The management of swallowing difficulty for one resident was examined. The prescribed fluid consistency was not recorded on the personal medication record; it was agreed that this would be added after the inspection. Each administration was recorded and a care plan and speech and language assessment report were in place.

Medicine records were well maintained and facilitated the audit process. The good practice of highlighting paracetamol warnings when a resident was prescribed two paracetamol containing medicines was acknowledged.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to residents' healthcare needs.

Areas for improvement

The necessary arrangements must be made to inform the prescriber when medicines are refused or not administered as prescribed; and to ensure that details are recorded in the residents' care files. A recommendation was made.

The management of distressed reactions should be reviewed. One element of the recommendation was stated for a second time.

Number of requirements	0	**Number of recommendations**	2

4.5 Is care compassionate?

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

Following discussion with staff, they confirmed that residents were given time to take their medicines and medicines were administered as discreetly as possible. They provided examples of how medicines were administered in accordance with the resident's preference e.g. bedroom or lounge.

It was found that there were good relationships between the staff, residents and relatives/ representatives. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was clear that the staff were familiar with the residents' likes and dislikes.

The resident spoken to had no concerns regarding the management of their medicines and advised that staff responded in a timely manner to any requests that they had made.

As part of the inspection process, questionnaires were issued to residents, their relatives/representatives and staff. Thirteen questionnaires were completed and returned. The responses were recorded as "very satisfied" or "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. A number of these had been updated in the last year. It was agreed that the controlled drugs procedures would be updated to reflect the day to day practices in the home after the inspection (see Section 4.2).

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware of what incidents may need to be reported to the safeguarding lead and safeguarding team.

A variety of medicines were audited each day by the staff; these were reviewed by the registered manager and she also completed an audit each month which included the medicine records and observation of staff practice. A review of the audit records indicated that satisfactory outcomes had been achieved.

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 spoke positively about their work, the good working relationships between staff and the support provided by the staff team.

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 Mary Theresa Hamill, Registered manager and the senor care staff on duty, 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 **RQIA web portal** 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 30 **Stated:** Second time **To be completed by:** 9 June 2017	It is recommended that the registered person should review the management of distressed reactions to ensure that the reason for and outcome of the administration are recorded on every occasion.
	Response by registered provider detailing the actions taken: Management of distressed reactions has been reviewed and outcome of administration are recorded on every occasion on medication administration sheets and in care plan
Recommendation 2 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 9 June 2017	The registered provider should ensure that the recording of new medicines information on personal medication records involves two staff, and both sign the entry.
	Response by registered provider detailing the actions taken: We have reviewed policy on new medications on all personal medication records to include signatures of two staff on new entries
Recommendation 3 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 9 June 2017	The registered provider should put a system in place to ensure that when medicines are not administered in accordance with the prescriber's instructions, this is reported to the prescriber for review and recorded in the residents' notes.
	Response by registered provider detailing the actions taken: A system is now in place to ensure that when medicines are not administered in accordance with the prescribers instructions this is reported immediately for review and this is recorded in the care notes

Please ensure this document is completed in full and returned to RQIA web portal

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