Unannounced Medicines Management Inspection Report
19 February 2019

Naroon House

Type of service: Residential Care Home
Address: 1 Ballyquillan Road, Crumlin, BT29 4DD
Tel No: 028 9445 2204
Inspector: Helen Daly

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 which provides care for up to 12 residents with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Naroon House **Responsible Individual:** Mrs Margaret Kelly	**Registered Manager:** Miss Mary Kelly
Person in charge at the time of inspection: Miss Mary Kelly	**Date manager registered:** 28 August 2015
Categories of care: Residential Care (RC): I – old age not falling within any other category LD – learning disability LD(E) – learning disability – over 65 years MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years	**Number of registered places:** 12

4.0 Inspection summary

An unannounced inspection took place on 19 February 2019 from 10.35 to 14.10.

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 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.

Evidence of good practice was found in relation to medicines administration, the completion of most medicine records, medicine storage and the management of controlled drugs.

Two areas for improvement were identified in relation to personal medication records and the management of self-administered medicines.

We spoke with four residents who were chatting with staff and seemed content 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	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Miss Mary Kelly, 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.

4.2 Action/enforcement taken following the most recent finance inspection

The most recent inspection of the home was an unannounced finance inspection undertaken on 12 October 2018. Other than those actions detailed in the QIP no further actions were required to be taken. 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
- recent correspondence with the home
- the management of medicine related incidents, it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

During the inspection we met with four residents, the domestic assistant, the registered manager and the registered person.

We provided the registered manager with 10 questionnaires to distribute to residents and their representatives, for completion and return to RQIA. We left 'Have we missed you?' cards in the home to inform residents/their representatives, how to contact RQIA to tell us of their experience of the quality of care provided. Flyers providing details of how to raise concerns were also left in the home.

We asked the registered manager 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 requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- care plans
- training records
- medicines storage temperatures
- policies and procedures

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 12 October 2018

The most recent inspection of the home was an unannounced finance inspection. The completed QIP was approved by the finance inspector. This QIP will be validated by the finance inspector at the next finance inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 4 August 2016

There were no areas for improvement identified as a result of the last 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. Training was provided annually by the community pharmacist. The most recent training had been provided in May 2018. Records were available for inspection. Competency assessments were currently being updated. The registered manager advised that all staff, including kitchen staff, had received training on the use of thickening agents.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training was provided annually, the most recent training had been provided in August 2018.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and to manage medication changes. Personal medication records were verified and signed by two trained staff when they were written. However, it was noted that updates on the personal medication records were not signed. An area for improvement with regards to the standard of maintenance of the personal medication records was made in Section 6.5.

There were systems in place to ensure that residents had a continuous supply of their prescribed medicines. There was evidence that antibiotics and newly prescribed medicines had been received into the home without delay.

Insulin was managed by the district nursing team. In-use insulin was stored at room temperature and staff had access to the district nursing notes. The prescribed insulin, including the current dose, was clearly recorded on the personal medication records and care plans. A file containing information on the management of hypoglycaemia was available for staff.

Where medicines were administered covertly a care plan was in place and authorisation had been obtained for the prescriber. The registered manager was reminded that pharmaceutical advice should be sought when medicines are mixed together or added to liquids to facilitate administration. The completion of care plans for covert administration of medicines was discussed; it was agreed that these would be expanded to ensure all relevant information regarding methods of administration were recorded.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Stock balance checks were performed on controlled drugs which require safe custody, at the end of each shift.

Satisfactory arrangements were in place for the safe disposal of discontinued or expired medicines.

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. A small number of medicines required cold storage. They were stored in a locked box in the domestic refrigerator. The maximum, minimum and current refrigerator temperatures were monitored daily.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

The majority of medicines examined had been administered in accordance with the prescriber's instructions. One discrepancy in the administration of an inhaled medicine was highlighted to

the registered manager. It was agreed that a daily running balance would be maintained and that any further discrepancies would be reported to the prescriber and RQIA.

A small number of residents self-administer their inhaled medicines. This had not been recorded on the personal medication records or recorded in a care plan. Records of the transfer of the inhalers to the residents had not been maintained. An area for improvement was identified.

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. Detailed protocols for their use were also available on the medicines file and the reason for and outcome of each administration were recorded. 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/infection. Staff had been advised to consult with management before administering these medicines and there was evidence that the registered manager contacted the resident's general practitioner if there was any deterioration in the resident's health. It was agreed that running stock balances for these medicines would be maintained.

The registered manager advised that regular pain relief was not prescribed for any residents. All residents had a supply of "when required" analgesia and protocols for their use were available on the medicines file. All residents could verbalise their pain and request pain relief.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, care plans and speech and language assessment reports were in place. All staff were aware of the recommended consistency levels and guidance was available in the kitchen. Records of prescribing and administration were not being maintained. The personal medication records were updated at the inspection and a template to record each administration was put in place. As this system was implemented during the inspection an area for improvement was not specified.

The registered manager advised 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.

The majority of medicine records were well maintained and facilitated the audit process, the registered manager and staff were commended for their ongoing efforts. However, updates on the personal medicine records had not been verified and signed by two trained staff and on some occasions when a dose had changed the entry on the personal medication record had been amended rather than discontinued and a new entry made. 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 several medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and registered nurses and care assistant, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in resident care.

Areas of good practice

There were examples of good practice in relation to the standard of most records, care planning and the administration of medicines.

Areas for improvement

The management of self-administered medicines should be reviewed and revised. Care plans should be in place. The self-administered medicines should be recorded on the personal medication records and a record of the transfer to the resident for self-administration should be maintained.

Two staff should verify and sign all updates on the personal medication records. When a dose has changed, the original entry on the personal medication record should be cancelled and a new entry made.

	Regulations	Standards
Total number of areas for improvement	0	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.

We observed the administration of medicines to a small number of residents. The registered manager engaged the residents in conversation and explained that they were having their medicines.

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 discussion and observation of staff, that the staff were familiar with the residents' likes and dislikes. Residents were observed to be relaxed and comfortable.

We spoke with four residents who seemed to be content in the home. One resident was celebrating a birthday and another resident had been shopping on-line.

As part of the inspection process, we issued 10 questionnaires to residents and their representatives. All ten were returned and the responses indicated that residents and their representatives were "satisfied" or "very satisfied" with all aspects of care.

Any comments from residents and their representatives in questionnaires received after the return date (two weeks) will be shared with the registered manager for information and action as required.

Areas of good practice

Staff were observed to listen to residents, engage them in conversation and respond promptly to their requests.

Areas for improvement

No areas for improvement were identified at this 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.

We 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. Arrangements were in place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. They had been updated in 2018. The registered manager was currently ensuring that all staff signed to acknowledge that they had read and understood the policy and procedures.

The registered manager advised that staff knew how to identify and report incidents and that they were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were examined. Management advised of the auditing processes completed by both staff and management. Any shortfalls were discussed immediately with staff for action.

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 governance arrangements and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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 Miss Mary Kelly, Registered Manager, 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 Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 19 March 2019	The registered person shall review and revise the management of self-administered medicines. Ref: 6.5
	Response by registered person detailing the actions taken: The management of self administered medicines has been reviewed and revised. This has been included in the resident's care plan and all staff also document and record the administration of self admininstered medicine.
Area for improvement 2 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 19 March 2019	The registered person shall ensure that updates on the personal medication record are recorded appropriately and verified and signed by two trained staff. Ref: 6.4 & 6.5
	Response by registered person detailing the actions taken: All staff have been informed of this standard and this has been put into practice with immediate effect.

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

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