Unannounced Medicines Management Inspection Report
19 October 2016

Clanrye

Type of service: Residential Care Home
Address: 128 Glenarm Road, Larne, BT40 1DZ
Tel No: 028 2827 5701
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Clanrye took place on 19 October 2016 from 09.50 to 13.10.

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. No requirements or recommendations were made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be caring and timely. 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 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	0

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Heather Leo, 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 those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 8 September 2016.

2.0 Service details

Registered organisation/registered person: Mrs Heather Margaret Leo	**Registered manager:** Mrs Heather Margaret Leo
Person in charge of the home at the time of inspection: Mrs Heather Leo	**Date manager registered:** 1 April 2005
Categories of care: RC-LD(E), RC-DE, RC-I, RC-MP(E)	**Number of registered places:** 17

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- 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 met with three residents, two senior care assistants 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:

- 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 8 September 2016

The most recent inspection of the home was an unannounced care inspection. The draft report has been issued. The completed QIP was returned and will be assessed 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 27 August 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must ensure that all residents have a continuous supply of their prescribed medicines.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that this issue had been addressed following the last inspection and this was evidenced in previous medication administration records. A new system of online ordering for medicines had begun recently at the request of the local surgeries. This caused a few initial problems which had been resolved by management. All medicines examined were available for administration. The registered manager agreed to continue to closely monitor the availability of all prescribed medicines. For this reason this requirement was assessed as met.	

Requirement 2 **Ref:** Regulation 19(2)(b) **Stated:** First time	The registered person must ensure that all relevant records are available for inspection at all times.	**Met**
	Action taken as confirmed during the inspection: The registered manager was present during the inspection. Staff confirmed that when management are not present, they now have access to the records not available at the last inspection as they have been relocated. Some recent audit records were not available for examination. The registered manager stated that these were held by the senior care assistant responsible for audit who was not on duty, but that any issues identified were escalated to management for action. It was agreed that these should also be available for examination at all times. Copies of recent audits were forwarded to RQIA following the inspection. This requirement was therefore assessed as met.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	It is recommended that the registered person should review the management of medicines prescribed on a "when required" basis for the management of distressed reactions, to ensure that a care plan is in place and that the reason for administration and the outcome are recorded on each occasion. The prescriber should be informed when these medicines are needed regularly.	**Met**
	Action taken as confirmed during the inspection: Records examined indicated that these medicines had not been used regularly since the last inspection. There was evidence that these medicines had been reviewed with the prescriber for several residents since the last inspection. Where prescribed, these medicines were recorded on the personal medication record; however a care plan was not in place. The registered manager stated that this was because these medicines had not been used recently. This was acknowledged, however it was agreed that when these medicines are prescribed this should be detailed in the care plan. As this was addressed immediately this recommendation was assessed as met.	

Recommendation 2 **Ref**: Standard 32 **Stated:** First time	It is recommended that the temperature of the medicines storage area is monitored and recorded on a daily basis and action taken as necessary to ensure that all medicines are stored according to the manufacturer's instructions.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the temperature is monitored. The temperature of the medicines storage area was observed to be satisfactory.	
Recommendation 3 **Ref**: Standard 30 **Stated:** First time	It is recommended that the registered person reviews the management of medicines prescribed for the management of pain to ensure that a care plan is in place.	**Met**
	Action taken as confirmed during the inspection: A separate care plan specific to pain was not always in place. However, following discussion with staff and residents and examination of other records, systems for the management of medicines prescribed for the management of pain were found to be satisfactory. A separate record of administration for analgesia prescribed on a "when required" basis was maintained, noting the reason for administration. This recommendation was therefore assessed as met.	

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.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Procedures were in place to identify and report any potential shortfalls in medicines (see 4.2).

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. Additional checks were also performed on other controlled drugs which is good practice.

Satisfactory arrangements were examined for the management of high risk medicines e.g. warfarin. 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 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

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 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. Details were recorded in the care plan for relevant residents following discussion. It was acknowledged that these medicines had not been used recently (see 4.2).

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 is completed as part of the admission process.

The management of swallowing difficulty was examined. For one resident a thickening agent had been prescribed recently, following discussion this was recorded on the personal medication record, including details of the fluid consistency. Care plans and speech and language assessment reports were in place.

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 throughout the month by the staff and management. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and senior care assistants, it was evident that when applicable, other healthcare professionals were contacted in response to issues or concerns 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.

Three residents advised that they were satisfied with the manner in which their medicines were managed and administered. They were complementary about the staff and their care 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. It was evident that staff were familiar with the policies and procedures and that any updates were highlighted to staff.

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

Records of audit indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and escalation to management. Staff were advised to ensure that a variety of medicine formulations are included in the audit process.

Following discussion with the registered manager and senior care assistant, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

The senior care assistant confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated to staff.

The requirements and recommendations made at the last medicines management inspection had been addressed. To ensure that these continue to be fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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