Unannounced Medicines Management Inspection Report
26 April 2018

Clanrye

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

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 registered to provide care for up to 17 residents with a variety of care needs as detailed in section 3.0.

3.0 Service details

Organisation/Registered Provider: Clanrye **Responsible Individual:** Mrs Heather Margaret Leo	**Registered Manager:** Mrs Heather Margaret Leo
Person in charge at the time of inspection: Ms Naomi Forsythe, Senior Care Assistant	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) I – Old age not falling within any other category DE – Dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years LD(E) – Learning disability – over 65 years	**Number of registered places:** 17 including: - a maximum of five existing residents in DE category of care - two named individuals in category RC-LD(E) The home is also approved to provide care on a day basis only to one person

4.0 Inspection summary

An unannounced inspection took place on 26 April 2018 from 09.45 to 13.25.

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 and the management of controlled drugs.

Areas for improvement were identified in relation to all relevant records being available for examination, the management of medicines on admission, the cold storage of medicines, care planning and the maintenance of some medicine records.

The residents spoken to advised that they were satisfied with the management of their medicines and the care provided 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	2	5

Details of the Quality Improvement Plan (QIP) were discussed with Ms Naomi Forsythe, Senior Care Assistant, 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 care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 30 January 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 and returned QIPs
- recent correspondence with the home
- the management of incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

During the inspection the inspector met with three residents, one visitor, one care assistant and the senior care assistant on duty.

A poster informing visitors to the home that an inspection was being conducted was displayed.

Ten questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views 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

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 30 January 2018

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.

6.2 Review of areas for improvement from the last medicines management inspection dated 19 October 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 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, discussion and annual appraisal. Competency assessments and training records were not available for inspection since these were locked in the manager's office (see section 6.7). Staff confirmed that refresher training in medicines management had been provided within the last year. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

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. All medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

The arrangements in place to manage changes to prescribed medicines were examined. Personal medication records and any new entries were not always updated and verified by two members of staff. This is necessary to ensure accuracy in transcription. An area for improvement was identified.

The procedures in place in relation to the management of medicines during a resident's admission to the home were examined. For one recently admitted resident, medicines had not been verified with the prescriber to confirm accuracy. This confirmation is necessary to ensure that the medicines regimen is accurate to ensure safe and effective care. Systems should be

reviewed to ensure that this takes place for every admission. An area for improvement was identified.

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.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored securely. 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. However, the medicine refrigerator thermometer was not working and staff completed the temperature monitoring chart during the inspection without measuring the temperature. Temperature record charts were not completed on a daily basis. Robust systems should be in place to accurately monitor maximum, minimum and current medicine refrigerator temperatures on a daily basis. All medicines must be stored in accordance with the manufacturer's instructions and this could not be verified. Two areas for improvement were identified.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training and the management of controlled drugs.

Areas for improvement

Personal medication records and any new entries should be updated and verified by two members of staff to ensure accuracy in transcription.

Systems should be reviewed to ensure that medicines are verified with the prescriber to confirm accuracy for every admission.

All medicines must be stored in accordance with the manufacturer's instructions.

Robust systems should be in place to accurately monitor maximum, minimum and current medicine refrigerator temperatures on a daily basis.

	Regulations	Standards
Total number of areas for improvement	1	3

6.5 Is care effective?

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

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 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. It was acknowledged that these medicines had not been administered recently. When administered, the reason for and the outcome of administration were usually recorded. However, a care plan was not in place. One area for improvement in relation to care planning was identified.

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 any pain was well controlled and the resident was comfortable. Staff advised that the residents could verbalise any pain. A care plan was not maintained for residents prescribed regular pain relief. One area for improvement in relation to care planning was identified.

The management of swallowing difficulty was examined. For one resident prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. A care plan and speech and language assessment report was 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 would be reported to the prescriber.

Medicine records were mostly well maintained and facilitated the audit process. However, some details were missing from several personal medication records, including the resident's date of birth, allergy status and the form of medication prescribed. In addition, medication administration records were often marked only with the resident's first name or a preferred name, which did not always match that on the personal medication record, these should correlate. An area for improvement was identified.

Practices for the management of medicines were audited by staff. Running stock balances were maintained for several medicines prescribed for use "when required". In addition, audits were completed by the community pharmacist.

Following discussion with the staff, it was evident that when applicable, other healthcare professionals are contacted in response to the needs of the residents.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the standard of most of the record keeping and the administration of medicines.

Areas for improvement

Care plans should include the management of pain and distressed reactions specific to the resident.

Personal medication records and medication administration records should be reviewed to ensure that all relevant details are included.

	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.

The administration of medicines to residents was not observed during this inspection. Following discussion with staff it was confirmed that residents were given time to take their medicines and medicines were given in accordance with the residents' preferences.

Throughout the inspection, good relationships were observed between the staff and the residents. It was clear, from discussion and observation of staff, that they were familiar with the residents' backgrounds and their likes and dislikes.

The residents spoken to advised that they were satisfied with the management of their medicines and the care provided in the home. Comments made included:

"I'm happy to be here, it was my decision."
"If I need anything, the staff sort it out."

Ten questionnaires were left in the home to facilitate feedback from residents and relatives. None were returned within the specified timescale (two weeks).

Any comments from residents, their representatives or staff received after the issue of this report will be shared with the registered manager for their information and action as required.

Areas of good practice

There was evidence that staff listened to residents and took account of their views.

Areas for improvement

No areas for improvement were identified during the 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.

The inspector 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. Staff confirmed that arrangements were in place to implement the collection of equality data within Clanrye.

Not all records were available for examination including staff training records and competency assessments in relation to medicines management, policies and procedures in relation to medicines management and any management audit records regarding the governance of

medicines. The availability of records had been raised at a previous medicines management inspection in August 2015 when no manager was on duty. The registered manager who was on duty at the last inspection in October 2016 had stated that staff had access to all records when management are not present. An area for improvement was identified.

There were arrangements in place for the management of any 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 that medicine incidents may need to be reported to the safeguarding team.

A review of the staff audit records indicated that satisfactory outcomes had been achieved.

Following discussion and observation, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with management.

No members of staff shared their views by completing the online questionnaire prior to the issue of this report.

Areas of good practice

There were clearly defined roles and responsibilities for staff.

Areas for improvement

All relevant records must be available for inspection at all times.

	Regulations	Standards
Total number of areas for improvement	1	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 Ms Naomi Forsythe, Senior Care Assistant, 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 24 May 2018	All medicines must be stored in accordance with the manufacturer's instructions. Ref: 6.4
	Response by registered person detailing the actions taken: New Fridge thermometer has been purchased and is in use. Staff have been reminded of the importance of recording fridge temps and monitoring what is stored in same.
Area for improvement 2 **Ref**: Regulation 19(3)(b) **Stated:** First time **To be completed by:** 24 May 2018	The registered person shall ensure that all relevant records are available for inspection at all times. Ref: 6.7
	Response by registered person detailing the actions taken: As a result of you being unable to access these documents we have assigned 1 more senior member of staff to have the keys to this office, this should prevent any issues arising in the future. We will also endeavour to have a basic informative spreadsheet available at the staff desk with names and dates of all staff that have completed their medicines training and competency and capability assessments.
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 31 **Stated:** First time **To be completed by:** 24 May 2018	The registered person shall ensure that personal medication records and any new entries are updated and verified by two members of staff to ensure accuracy in transcription. Ref: 6.4
	Response by registered person detailing the actions taken: New complete meds recording file has been implemented, with all relevant detail clear and concisely recorded
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 24 May 2018	The registered person shall ensure that systems are reviewed to ensure that medicine details are verified with the prescriber to confirm accuracy for every admission. Ref: 6.4
	Response by registered person detailing the actions taken: Will ensure this is carried out in a time efficient manner in future

Area for improvement 3 **Ref**: Standard 32 **Stated:** First time **To be completed by:** 24 May 2018	The registered person shall ensure that robust systems are in place to accurately monitor maximum, minimum and current medicine refrigerator temperatures on a daily basis. Ref: 6.4
	Response by registered person detailing the actions taken: New Fridge thermometer has been purchased and is in use. Staff have been reminded of the importance of recording fridge temps and monitoring what is stored in same
Area for improvement 4 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 24 May 2018	The registered person shall ensure that care plans include the management of pain and distressed reactions specific to the resident. Ref: 6.5
	Response by registered person detailing the actions taken: All care plans have been updated to include this detail
Area for improvement 5 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 24 May 2018	Personal medication records and medication administration records should be reviewed to ensure that all relevant details are included.
	Response by registered person detailing the actions taken: As before

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

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