Clanrye
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Larne
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Unannounced Medicines Management Inspection of Clanrye

27 August 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced medicines management inspection took place on 27 August 2015 from 10:50 to 14:15.

Overall on the day of the inspection the management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no significant areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

This inspection was underpinned by The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last medicines management inspection on 30 July 2013.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**2**	**3**

The details of the QIP within this report were discussed with the senior care assistant in charge of the home at the time of the inspection, Ms Donna Clarke as part of the inspection process. The timescales for completion commence from the date of inspection.

2. 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: Ms Donna Clarke (Senior Care Assistant)	**Date Manager Registered:** 1 April 2005
Categories of Care: RC-LD(E), RC-DE, RC-I, RC-MP(E)	**Number of Registered Places:** 17
Number of Residents Accommodated on Day of Inspection: 16	**Weekly Tariff at Time of Inspection:** £490

3. Inspection Focus

This inspection was carried out in response to correspondence received by RQIA on 13 August 2015 from the Northern Health and Social Care Trust detailing concerns including the following areas of medicines management:

- Medicines prescribed for administration on a 'when required' basis being administered regularly but the reason for and outcome of use not being recorded;
- Warfarin management; and
- Controlled drug management.

It is not the remit of RQIA to investigate complaints made by or on behalf of individuals, as this is the responsibility of the providers and commissioners of care. However, if RQIA is notified of a potential breach of regulations or associated standards it will review the matter and take whatever appropriate action is required; this may include an inspection of the home.

Following discussion with senior management it was agreed that an inspection would be undertaken to review both the areas above and the following:

The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011):

Standard 30: Management of medicines
Standard 31: Medicine records
Standard 33: Administration of medicines

Theme 1: Medicines prescribed on a "when required" basis for the management of distressed reactions are administered and managed appropriately.

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately.

The inspection also sought to assess progress with the issues raised during and since the last medicines management inspection.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to inspection the following records were examined:

- the management of incidents reported to RQIA since the last medicines management inspection; and
- information received from the Northern Health and Social Care Trust.

During the inspection the inspector met with the senior care assistant in charge of the home at the time of the inspection, Ms Donna Clarke.

The following records were examined during the inspection:

Medicines requested and received	Medicine audits
Personal medication records	Policies and procedures
Medicine administration records	Care plans
Medicines disposed of or transferred	Training records
Controlled drug record book	Medicine storage temperatures

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 18 and 20 August 2015. The report was pending at the time of this inspection.

5.2 Review of Recommendations from the Last Medicines Management Inspection

Last Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 31 **Stated twice**	The registered manager should ensure that prescribed dosage directions are included in the record of medicines received into the home.	**Met**
	Action taken as confirmed during the inspection: The record of medicines received did not routinely include the prescribed dosage directions; however this information was available. Photocopies of all prescriptions are kept in the home and the senior care assistant advised that prescriptions are routinely checked against the medicines order before being forwarded to the pharmacy for dispensing. Medicines received are additionally checked against the personal medication record and any discrepancies investigated. Records of medicines ordered and prescriptions received were observed.	

Recommendation 2 **Ref**: Standard 30 **Stated once**	The registered manager should ensure that the practice of crushing medicines for individual residents is reviewed on at least an annual basis. Evidence that professional advice has been sought with regard to this practice should be in place. This practice should additionally be documented on the personal medication record.	
	Action taken as confirmed during the inspection: The senior care assistant advised that medicines are no longer crushed for any resident. However, for one resident, some of whose medicines were previously crushed; authorisation from the prescriber was observed to be in place and had been reviewed annually since the last medicines management inspection. This was recorded on the personal medication record. This recommendation will not be restated.	**Not applicable**

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

The audits which were completed at the inspection produced satisfactory outcomes indicating that the medicines had been administered as prescribed.

Although systems were in place to manage the ordering of prescribed medicines and to prevent wastage, several examples of medicines being unavailable for administration on more than one occasion were observed for several residents. RQIA had not been notified of these incidents.

There was evidence that robust arrangements were in place to ensure the safe management of medicines during a resident's admission to the home. Medication details were confirmed with the prescriber and personal medication record sheets had been completed and checked by two staff members.

Medicine records were legible and accurately maintained so as to ensure a clear audit trail. Records of the ordering, receipt, administration, disposal and transfer of medicines were well maintained. Some incomplete details on recently written personal medication records were highlighted for attention.

There were no Schedule 2 or 3 controlled drugs prescribed for any resident at the time of the inspection. Stock balances of all Schedule 4 (Part 1) controlled drugs had been reconciled on each occasion when the responsibility for safe custody was transferred which is good practice. Records were examined and stock balances were correct.

Any medicines which had been discontinued or were unsuitable for use had been returned to the community pharmacy for disposal and records maintained.

Anticoagulant medication was not prescribed for any resident on the day of the inspection. The senior care assistant confirmed that changes to warfarin doses are routinely confirmed in writing, via facsimile from the prescriber. Two members of staff are involved in transcribing warfarin doses onto personal medication records and a daily stock balance is recorded for warfarin. These procedures are considered safe practice.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines were not available for inspection. The senior care assistant in charge of the home did not have access to these or to archived care plans and medication records, or to staff training and competency assessment records. This was discussed with regard to the regulations and the availability of records in the manager's absence.

The senior care assistant confirmed that medicines were managed by staff who have been trained and deemed competent to do so by the registered manager. Medicines management training was provided every six months by the registered manager and the impact of training was monitored through supervision and appraisal; these respectively take place every six months and annually.

There was an up to date list of staff names and sample signatures.

There were systems in place to audit practices for the management of medicines. The audit process was facilitated by the good practice of recording the date of opening on the medicine container.

Is Care Compassionate? (Quality of Care)

The records for several residents prescribed medication for administration "when required" for the management of distressed reactions were examined. A care plan was not in place for the management of distressed reactions. The parameters for administration were recorded on the personal medication records and the medicine administration records indicated that the medicines were being administered in accordance with the prescribers' instructions. However, the reason for and outcome of the administration of these medicines were not always recorded. For one resident a "when required" anxiolytic medicine was being administered regularly in the evening. The reason for this was not documented and there was no care plan in place. From the evidence it was concluded that further improvement is necessary regarding the management of distressed reactions and care planning.

The records for several residents prescribed medication for the management of pain were examined. The parameters for administration were recorded on the personal medication records. The senior care assistant confirmed that current residents can tell staff if they are in pain and that staff were aware of the signs, symptoms and triggers of pain in residents. A separate record was maintained of the administration of "when required" analgesia including the reason. A running stock balance was maintained for these medicines. A care plan was not in place for relevant residents regarding the management of pain and the use of analgesia.

Areas for Improvement

The registered person must ensure that all residents have a continuous supply of their prescribed medicines. A requirement was made.

The registered person must ensure that all relevant records are available for inspection at all times. A requirement was made.

The registered person should review the management of medicines prescribed for use 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. A recommendation was made.

The registered person should review the management of medicines prescribed for the management of pain to ensure that a care plan is in place.

It was agreed that obsolete personal medication records would be cancelled and archived.

Some discrepancies in the personal medication records were discussed with the senior care assistant on duty for corrective action.

The management of medication related incidents was discussed.

In relation to the medicine management concerns raised by the Trust, it was identified that improvement is required in the management of medicines prescribed for use on a "when required" basis for the management of distressed reactions.

Number of Requirements:	**2**	**Number of Recommendations**:	**2**

5.4 Additional Areas Examined

Storage of medicines was observed to be tidy and organised.

The maximum, minimum and current temperature of the medicines refrigerator was being monitored and recorded each day; records were examined and found to be satisfactory. Staff were reminded to reset the thermometer daily.

The temperature of the medicines storage area was 27.5^{o}C at the time of the inspection. The majority of medicines should be stored below 25^{o} C. The temperature of the medicines storage area should be 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. A recommendation was made.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Donna Clarke, Senior Care Assistant as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The DHPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Residential Care Homes Regulations (Northern Ireland) 2005.

6.2 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 person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Person/Registered Manager

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to RQIA and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated: First time** **To be Completed by:** **26 September 2015**	The registered person must ensure that all residents have a continuous supply of their prescribed medicines. **Response by Registered Person(s) Detailing the Actions Taken:** Complete + ongoing. we have liased with GP surgeries to ensure more timely ordering/prescription service
Requirement 2 **Ref:** Regulation 19(2)(b) **Stated: First time** **To be Completed by:** **26 September 2015**	The registered person must ensure that all relevant records are available for inspection at all times. **Response by Registered Person(s) Detailing the Actions Taken:** Complete + ongoing
Recommendations	
Recommendation 1 **Ref**: Standard 30 **Stated: First time** **To be Completed by:** **26 September 2015**	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. **Response by Registered Person(s) Detailing the Actions Taken:** Complete + ongoing Care plans updated.

Recommendation 2 **Ref**: Standard 32 **Stated: First time** **To be Completed by:** **26 September 2015**	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. **Response by Registered Person(s) Detailing the Actions Taken:** We have begun monitoring the temp of the room in which the trolley is stored
Recommendation 3 **Ref**: Standard 30 **Stated: First time** **To be Completed by:** **26 September 2015**	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. **Response by Registered Person(s) Detailing the Actions Taken:** Reg careplans have been updated

Registered Manager Completing QIP	[signature]	**Date Completed**	01-10-15
Registered Person Approving QIP	[signature]	**Date Approved**	01-10-15
RQIA Inspector Assessing Response		**Date Approved**	

Please ensure the QIP is completed in full and returned to RQIA

The Regulation and Quality Improvement Authority

RQIA Inspector Assessing Response	Rachel Lloyd	**Date Approved**	8/10/2015