

Unannounced Medicines Management Inspection Report 20 July 2017



Colebrooke House

Type of service: Residential Care Home
Address: 111 The Roddens, Larne, BT40 1PY
Tel No: 028 2827 2696
Inspector: Helen Daly

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 with 12 beds that provides care for residents over 65 years of age. Care can be provided for six identified individuals who are living with dementia.

3.0 Service details

Organisation/Registered Provider: Colebrooke House Responsible Individual(s): Mrs Anne Marie Rowan	Registered Manager: Mrs Caroline Lockwood
Person in charge at the time of inspection: Mrs Caroline Lockwood	Date manager registered: 8 August 2015
Categories of care: Residential Care (RC) I – old age not falling within any other category DE – dementia	Number of registered places: 12 Category DE (Dementia) for 6 identified individuals with mild/moderate dementia

4.0 Inspection summary

An unannounced inspection took place on 20 July 2017 from 10.40 to 13.10.

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 during and 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 records, staff training, the management of medicines on admission and the management of medication changes.

There were no areas identified for improvement.

One resident said: “This is a lovely place. Caroline knows all about the medicines, she is wonderful.”

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Caroline Lockwood, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 13 April 2017.

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 which had been reported to RQIA since the last medicines management inspection

During the inspection the inspector met with one resident, one care assistant and the registered manager.

A total of 15 questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA.

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

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

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 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 13 April 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.

6.2 Review of areas for improvement from the last medicines management inspection dated 29 June 2015

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 13 (4) Stated: Second time	The registered manager must review the management of records relating to prescribed thickening agents.	Met
	Action taken as confirmed during the inspection: Records of prescribing and administration were now maintained.	
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		Validation of compliance
Area for improvement 1 Ref: Standard 30 Stated: Second time	Written Standard Operating Procedures (SOPs) should be developed for the management of controlled drugs.	Met
	Action taken as confirmed during the inspection: Standard Operating Procedures (SOPs) had been developed and implemented following the last medicines management inspection. Controlled drugs were not currently prescribed.	

Area for improvement 2 Ref: Standard 30 Stated: First time	It is recommended that the registered person ensures that detailed care plans are in place for the management of distressed reactions for all designated residents.	Met
	Action taken as confirmed during the inspection: Four care plans were reviewed. More detail was required for two of these care plans. The registered manager advised that this would be completed immediately following the inspection. Due to the assurances provided and the infrequent use of these medicines this area for improvement was assessed as met.	
Area for improvement 3 Ref: Standard 30 Stated: First time	It is recommended that the registered person ensures that detailed care plans are in place for the management of pain for all designated residents.	Met
	Action taken as confirmed during the inspection: Detailed care plans for the management of pain were in place.	

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. An induction process was in place for care staff who had been delegated medicine related tasks. The impact of training was monitored through the home's audit process and supervision. Plans were in place to complete competency assessments annually.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. This safe practice was acknowledged.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed in October 2016.

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.

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 of good practice

There were examples of good practice in relation to staff training, the management of medicines on admission and the storage of medicines.

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 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.

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. Care plans were in place. 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 an infection or pain. The reason for and the outcome of administration were recorded in the daily progress notes.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place which detailed the cause of the resident’s pain. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. All residents could verbalise their pain.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Care plans were in place. Administration was being recorded.

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. Areas of good practice were acknowledged. They included the additional recording sheets for antibiotics.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several medicines and “end of box” audits. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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 had been completed prior to the commencement of this inspection and was not observed. Staff were knowledgeable about the administration of medicines process. There was evidence that staff looked up newly prescribed medicines to find out if there was any additional guidance on administration or side effects.

Of the questionnaires that were issued, one was returned from a resident, three from relatives and one from staff. The responses indicated that they were very satisfied with all aspects of the care in relation to the management of medicines. One relative made the following comment “Compassionate care is one of the hallmarks of this home. Residents are treated with love and respect.”

We spoke with one resident who said that the home was a lovely place and that staff were very kind.

Residents were observed to be relaxed and comfortable.

Areas of good practice

Staff listened to residents and relatives 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.

Written policies and procedures for the management of medicines were in place. The registered manager advised that they were reviewed regularly and that any updates were discussed with staff.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented. In relation to the regional safeguarding procedures, the registered manager confirmed that staff were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

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 could be raised with management and that corrective action was taken without delay.

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents 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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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