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The Regulation and Quality Improvement Authority

Hob Green Country Home
RQIA ID: 1337
41 Kirk Road
Ballymoney
BT53 8HB

Inspector: Cathy Wilkinson
Inspection ID: IN022457

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Unannounced Medicines Management Inspection of Hob Green Country Home

15 July 2015

1. Summary of Inspection

An unannounced medicines management inspection took place on 15 July from 11:10 to 12:45.

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 areas of concern. A Quality Improvement Plan (QIP) was not included in 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 10 December 2012.

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	0	0

The details of the QIP within this report were discussed with Ms Linda Jamison, Deputy Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Hob Green Country Home Mrs Elizabeth Kathleen Mary Lisk	**Registered Manager:** Mrs Mary Elizabeth McVicker
Person in Charge of the Home at the Time of Inspection: Ms Linda Jamison (Deputy Manager)	**Date Manager Registered:** 3 October 2007
Categories of Care: RC-MP(E), RC-I, RC-DE	**Number of Registered Places:** 9
Number of Residents Accommodated on Day of Inspection: 9	**Weekly Tariff at Time of Inspection:** £470 - £490

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and to determine if the following standards and themes have been met:

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.

4. Methods/Process

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

Prior to the inspection, the inspector reviewed the management of incidents reported to RQIA since the last medicines management inspection.

The following records were examined during the inspection:

Medicines requested and received
Personal medication records
Medicines administration records (MARs)
Medicines disposed of or transferred
Medicine audits
Policies and procedures
Care plans
Training records.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced care inspection dated 23 June 2015. The report had just been issued prior to this inspection and the QIP had not yet been returned. Any outstanding issues will be followed up by the care inspector.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Inspection

Last Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref: Regulation 13(4)** **Stated once**	The registered manager must ensure that the full dosage instructions are recorded on the personal medication record and medication administration records (MARs).	**Met**
	Action taken as confirmed during the inspection: Full dosage instructions had been recorded on both of these records.	
Last Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref: Standard 30** **Stated once**	Updates to the personal medication record should be verified and signed by two members of staff.	**Met**
	Action taken as confirmed during the inspection: All updates had been signed by two staff members.	
Recommendation 2 **Ref: Standard 30** **Stated once**	The administration record for Didronel PMO should indicate which of the two tablets within the pack has been administered.	**No longer applicable**
	Action taken as confirmed during the inspection: This medicine is no longer prescribed for any residents.	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

Medicines were being administered in accordance with the prescribers' instructions. The majority of medicines were contained in a blister pack system. The small number of audit trails completed during this inspection produced satisfactory outcomes.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage.

Medicine records were legible and accurately maintained to ensure that there was a clear audit trail. Personal medication records had been signed and verified by two staff members. Printouts of the medicines prescribed by the general practitioner were also held on file.

The management of bisphosphonate medicines was discussed. The record of administration of these medicines indicated that they were being administered at the same time as the other morning medicines however, the deputy manager advised that they were given before the other medicines. The record of administration must accurately reflect the time of administration. It was agreed that the time recorded on the MARs would be rectified after the inspection.

Disposal of medicines no longer required was being undertaken by trained and competent staff. Any discontinued or expired medicines were returned to the community pharmacist and records were fully maintained.

No controlled drugs requiring safe custody were prescribed at the time of this inspection.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines were in place. There were up to date Standard Operating Procedures for the management of controlled drugs.

Suitable arrangements were in place to ensure that the management of medicines is undertaken by qualified, trained and competent staff and systems were in place to review staff competency in the management of medicines. A record was maintained of medicines management training and development activities. An annual capability and competency assessment was carried out with staff. A sample of records was provided for inspection.

There were arrangements in place to audit all aspects of the management of medicines. A medicines audit had been carried out for all residents' medicines on a monthly basis. Copies of these audits were available for inspection.

Is Care Compassionate? (Quality of Care)

The records for two residents who were prescribed an anxiolytic medicine for administration on a "when required" basis in the management of distressed reactions was examined. The medicine records were legibly and accurately maintained to ensure that there was a clear audit trail. The parameters for administration were recorded on the personal medication record. A record of administration had been maintained on the MARs. The reason for and outcome of administering the medicine had not been recorded. A care plan was not in place, however, the deputy manager has a form which covers all the areas that would be expected in a care plan. This was discussed and it was agreed that this form would be completed for the specified residents and placed on the medicine file following the inspection. The deputy manager agreed to record the reason for and outcome of the administration of these medicines on the reverse of the MARs sheets.

Pain management medicines were prescribed as necessary and when administered their effect had been monitored to ensure that they provide relief and that the resident is comfortable. The records for one patient who was prescribed medicines for the management of pain were reviewed. The names of the medicines and the parameters for administration had been recorded on the personal medication record. The administration had been recorded on the MARs. Pain scales for the assessment of residents' pain were observed on the medicines file.

Areas for Improvement

The management of "when required" medicines for the management of distressed reactions should be reviewed as discussed.

The time recorded for the administration of bisphosphonates should be accurately recorded on the MARs sheets.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.4 Additional Areas Examined

Medicines were safely and securely stored in accordance with the manufacturers' instructions.

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Betty McVicker	**Date Completed**	24/07/15
Registered Person	Elizabeth Lisk	**Date Approved**	28/07/15
RQIA Inspector Assessing Response		**Date Approved**	

Please provide any additional comments or observations you may wish to make below:

Please complete in full and returned to pharmacists@rqia.org.uk from the authorised email address

RQIA Inspector Assessing Response	Cathy Wilkinson	**Date Approved**	10/08/2015