

# Unannounced Medicines Management Inspection Report 25 April 2017



## Fairways - Duncreggan

Type of service: Residential Care Home  
Address: Duncreggan, 10 Mark Street, Portrush, BT56 8BT  
Tel No: 028 7082 4287  
Inspector: Rachel Lloyd

[www.rqia.org.uk](http://www.rqia.org.uk)

Assurance, Challenge and Improvement in Health and Social Care

## 1.0 Summary

An unannounced inspection of Fairways - Duncreggan took place on 25 April 2017 from 11.00 to 14.10.

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 largely in compliance with legislative requirements and standards. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. One area for improvement was identified in relation to record keeping. One recommendation was 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. There were no areas for improvement identified.

### Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for residents. There were no areas for improvement identified.

### 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 related incidents and medicine audit activity. There were no areas for improvement identified.

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
<b>Total number of requirements and recommendations made at this inspection</b>	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Sonia Bradley, 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

There were no further actions required to be taken following the most recent inspection dated 7 February 2017.

## 2.0 Service details

<b>Registered organisation/registered person:</b> Fairways Duncreggan Ltd Robert Anthony (Tony) Dunlop	<b>Registered manager:</b> Sonia Bradley
<b>Person in charge of the home at the time of inspection:</b> Sarah Toner (Senior Care Assistant) at start of inspection Sonia Bradley from 12.15	<b>Date manager registered:</b> 1 April 2005
<b>Categories of care:</b> LD, LD(E) with associated physical disabilities	<b>Number of registered places:</b> 21

## 3.0 Methods/processes

Prior to the inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related 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 one resident, one senior care assistant 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.

Fifteen questionnaires were issued to residents, residents' relatives/representatives and staff, with a request that these were completed and returned to RQIA within one week of the inspection.

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

#### 4.0 The inspection

#### 4.1 Review of requirements and recommendations from the most recent inspection dated 7 February 2017

The most recent inspection of the home was an unannounced care inspection. There were no actions required to be taken following the inspection.

#### 4.2 Review of recommendations from the last medicines management inspection dated 11 November 2014

Last medicines management inspection recommendations		Validation of compliance
<b>Recommendation 1</b> <b>Ref:</b> Standard 30 <b>Stated:</b> First time	The registered manager should review the management of external preparations.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> There was evidence that this had been reviewed and the management of the sample of preparations examined was appropriate.	
<b>Recommendation 2</b> <b>Ref:</b> Standard 30 <b>Stated:</b> First time	The registered manager should ensure that a daily stock balance is recorded for warfarin.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> No residents were prescribed warfarin. However, evidence that this recommendation had been met was observed in previous medication records and confirmed during discussion with staff.	
<b>Recommendation 3</b> <b>Ref:</b> Standard 30 <b>Stated:</b> First time	The registered manager should ensure that regular control checks of blood glucose monitors take place in accordance with the manufacturers' instructions, and that records are maintained.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> This was evidenced during the inspection. Satisfactory records of weekly control checks were in place.	

### 4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management and diabetes management was provided annually.

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. There were safe systems in place for obtaining and storing prescriptions until they were dispensed.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were checked by two members of staff. However, new entries on personal medication records and handwritten entries on printed medication administration records were not checked for accuracy and signed by two competent members of staff. A recommendation was made.

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.

Satisfactory arrangements were in place for administering medicines in disguised form or for crushing some tablets to make them easier to swallow.

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. Medicine refrigerators were checked at regular intervals.

#### Areas for improvement

New entries on personal medication records and handwritten entries on printed medication administration records should be checked for accuracy and signed by two competent members of staff. A recommendation was made.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	1
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### 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 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. The reason for and the outcome of administration were usually recorded. A care plan was maintained.

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 most of the residents could verbalise any pain and knew how the residents would express pain. A care plan was maintained for those prescribed regular analgesia.

The management of swallowing difficulty was examined and found to be satisfactory.

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 largely well maintained and facilitated the audit process. Stock balances for medicines not dispensed in the monitored dosage system were carried forward at the start of each new cycle which is good practice.

Practices for the management of medicines were audited throughout the month. In addition, a regular audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to matters relating to medicines management.

### Areas for improvement

No areas for improvement were identified during the inspection.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	0
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### 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. Good relationships were observed between staff and residents.

Residents who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

It was not possible to ascertain the views and opinions of residents on the management of medicines.

As part of the inspection process, questionnaires were issued to residents, relatives/residents' representatives and staff. No responses were received within the specified timescale.

## Areas for improvement

No areas for improvement were identified during the inspection.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	0
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### 4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. These had been updated in October 2016. Following discussion with staff, it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

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

A review of the audit records indicated that good outcomes had been achieved. Staff advised of the procedures in place to ensure that appropriate action was taken should a discrepancy arise.

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 registered manager confirmed that staff had received training on adult safeguarding and were aware that medication incidents may need to be reported to the adult safeguarding lead.

Staff confirmed that any concerns in relation to medicines management were raised with management and outcomes shared with staff.

## Areas for improvement

No areas for improvement were identified during the inspection.

<b>Number of requirements</b>	0	<b>Number of recommendations</b>	0
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### 5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Sonia Bradley, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 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.

### 5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Residential Care Homes Regulations (Northern Ireland) 2005.

### 5.2 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 provider/manager may enhance service, quality and delivery.

### 5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to the web portal for assessment by the inspector.

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. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.



## Quality Improvement Plan

### Recommendation

<p><b>Recommendation 1</b></p> <p><b>Ref:</b> Standard 31</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 24 May 2017</p>	<p>The registered provider should ensure that new entries on personal medication records and handwritten entries on printed medication administration records are checked for accuracy and signed by two competent members of staff.</p>
	<p><b>Response by registered provider detailing the actions taken:</b> New medication entries on the Marr sheet will be checked and signed by two competent members of staff</p>

*\*Please ensure this document is completed in full and returned via web portal \**



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