Unannounced Medicines Management Inspection Report
15 May 2017

Anniscliff House

Type of service: Residential Care Home
Address: 141 Moneysharvin Road, Maghera, BT46 5HZ
Tel No: 028 7964 2729
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Anniscliff House took place on 15 May 2017 from 10.25 to 14.00.

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 largely satisfactory systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. Two areas for improvement were identified in relation to medicine changes and new resident's medicines. Two recommendations were made.

Is care effective?

Most areas of the management of medicines supported the delivery of effective care. There were systems in place to ensure residents were receiving their medicines as prescribed. Care plans relating to specific areas of medicines management were maintained. Some areas for improvement were identified in relation to distressed reactions, refusal of medicines and external preparations. One requirement and two recommendations were made.

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. Residents consulted with confirmed that they were administered their medicines appropriately. No requirements or recommendations were made.

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.

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
Total number of requirements and recommendations made at this inspection	1	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Bernadette McGilligan, 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

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 10 January 2017.

2.0 Service details

Registered organisation/registered person: Mrs J Davies / Mrs Bernadette McGilligan	**Registered manager:** Mrs Bernadette McGilligan
Person in charge of the home at the time of inspection: Mrs Bernadette McGilligan	**Date manager registered:** 1 April 2005
Categories of care: RC-MP, RC-LD(E), RC-DE, RC-I, RC-MP(E)	**Number of registered places:** 17

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the incidents register: it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with one resident, two senior care staff 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.

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

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 10 January 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.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 27 July 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	It is recommended that care plans should be developed for residents who are prescribed medication for administration on a "when required" basis for the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: A small number of residents are prescribed medicines for distressed reactions. Care plans or behaviour support plans were in place. The detail in these was discussed and it was agreed that this would be added after the inspection.	

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, dementia and safeguarding had been provided in the last year.

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. Suitable arrangements were in place for the safe storage of prescriptions.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. Antibiotics and new medicines had been received and commenced in a timely manner. However, updates to the resident's personal medication records were not signed and verified by two members of staff. This should be addressed to ensure safe practice. A recommendation was made.

The procedures in place for the admission of a resident were examined. Where a resident was admitted as a permanent placement, the relevant records were maintained. However, when a resident was admitted for a period of respite care, written confirmation of the medicine regimes had not been obtained for two new residents. The registered manager agreed to contact the prescriber later on the day of the inspection. A recommendation was made.

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.

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 ensure that eye drops were marked with the date of opening and replaced in a timely manner. One expired external preparation was removed from stock.

Areas for improvement

Any updates to the personal medication records should be signed and verified by two staff. A recommendation was made.

The registered manager should ensure that written confirmation of medicines regimes is obtained for all new residents. A recommendation was made.

Number of requirements	0	**Number of recommendations**	2

4.4 Is care effective?

Most medicines were supplied in a seven day monitored dosage system. These were labelled appropriately.

The majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. There were a few discrepancies and these were highlighted at the inspection. The registered manager gave assurances that these would be monitored as part of the audit process.

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. When administered, the reason for and outcome of the administration had not been recorded. A recommendation was made. The registered manager confirmed that staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour. Staff were reminded that they should also consider that the distressed reaction may be due to pain.

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 for those that couldn't, they provided examples of how this would be expressed by the resident. A care plan was maintained.

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. They provided examples of where the medicine formulation had been changed from tablets to liquid to assist swallowing and compliance. There was evidence in one resident's care plan regarding the ongoing refusal of one medicine; however, for another resident who refused medicines on a frequent basis, there was no evidence that this had been reported to the prescriber. This should be addressed and it was suggested that a care plan should be developed. A recommendation regarding the non-administration of medicines was made.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for antibiotics. However, the management of external preparations must be reviewed. The personal medication records did not include all of the external preparations prescribed and when administered by the care staff, this was not recorded. All prescribed medicines must be recorded on the personal medication record and records of administration must be maintained. It was also noted that the audit trails on two external preparations indicated that they were not being administered as prescribed. One requirement was made.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to the residents' healthcare needs.

Areas for improvement

When medicines are required to be administered for the management of distressed reactions, a record of the reason for and outcome of the administration should be maintained. A recommendation was made.

The ongoing non-administration of medicines due to refusal or as identified at the inspection should be referred to the prescriber. A recommendation was made.

Robust arrangements must be in place for the management of external preparations. A requirement was made.

Number of requirements	1	**Number of recommendations**	2

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.

Throughout the inspection, it was found that there were good relationships between the staff and the residents. Staff were noted to be friendly and courteous; they treated the residents with dignity.

Following discussion with the registered manager and staff, it was clear that they were familiar with the residents' needs, their likes and dislikes.

The resident spoken to had no concerns regarding the management of their medicines and advised that staff responded in a timely manner to any requests that they had.

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.

As part of the inspection process, questionnaires were issued to residents, their relatives/representatives and staff. Eleven questionnaires were completed and returned. The responses were recorded as “very satisfied” or “satisfied” with the management of medicines in the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Staff confirmed that written policies and procedures for the management of medicines were in place. These were not examined in detail. 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 robust arrangements in place for the management of 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 of what incidents may need to be reported to the safeguarding lead and safeguarding team.

A variety of internal auditing systems were in place for medicines management. They included weekly and monthly audits. An audit was also completed by the registered manager and audits were completed by the community pharmacist. A review of the internal audit records indicated that largely satisfactory outcomes had been achieved. Where areas for improvement had been identified, these were investigated and also raised with staff.

Following discussion with the manager and staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

The staff confirmed that any concerns were raised with management. They spoke positively about their work and the good working relationships between the staff and other healthcare professionals.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Bernadette McGilligan, 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 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

Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 15 June 2017	The registered provider must ensure that robust arrangements are in place for the management of external preparations.
	Response by registered provider detailing the actions taken: All external preparations prescribed have now been added to each resident's medication record sheet and administered as per GP guidelines and recorded at each time of administration. Staff have been individually notified of this requirement and again at staff meeting held on the 20th June'17.
Recommendations	
Recommendation 1 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 15 June 2017	The registered provider should ensure that all updates to personal medication records involves two staff, and both sign the entry.
	Response by registered provider detailing the actions taken: All staff individually notified and again at staff meeting held on the 20th June'17 to ensure that all updates to personal medication records involve two staff, and both staff to sign the entry.
Recommendation 2 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 15 June 2017	The registered provider should ensure that written confirmation of medicines regimes is obtained for all new residents.
	Response by registered provider detailing the actions taken: All staff who administer medications have been individually notified, and again at staff meeting held on the 20th June'17 to ensure they obtain written confirmation of medication regimes for all new residents on admission.
Recommendation 3 **Ref**: Standard 8 **Stated:** First time **To be completed by:** 15 June 2017	The registered provider should ensure that the reason for and outcome of administration is recorded on each occasion a medicine is administered for distressed reactions.
	Response by registered provider detailing the actions taken: The registered provider has developed a distressed reaction plan for all residents to include the reason for the administration of medication and the outcome of administration. All senior staff have been individually notified of this and again revised at staff meeting on the 20th June'17.

Recommendation 4 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 15 June 2017	The registered provider should ensure that any ongoing refusal or non-administration of medicines is reported to the prescriber and recorded in the residents' notes.
	Response by registered provider detailing the actions taken: The registered provider has been in contact with resident's GP's to ensure that any ongoing refusal or non-administration of medication is actioned. The outcome provided by the GP has been recorded in the relevant resident's care-notes. All senior staff have been updated on this and again revised at recent staff meeting held on the 20th June'17.

Please ensure this document is completed in full and returned to RQIA web portal*

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