Unannounced Medicines Management Inspection Report
11 June 2018

Andena

Type of service: Residential Care Home
Address: 206-208 Ballymoney Road, Ballymena, BT43 5HG
Tel No: 028 2564 4767
Inspector: Judith Taylor

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 36 beds that provides care for residents living with healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Mr James Joseph McConville	**Registered Manager:** Mrs Christina Ann Shields
Person in charge at the time of inspection: Mrs Christina Ann Shields	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC): I – Old age not falling within any other category DE – Dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years	**Number of registered places:** 36

4.0 Inspection summary

An unannounced inspection took place on 11 June 2018 from 10.20 to 13.25.

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 the governance arrangements, training, medicine administration, the completion of most medicine records, medicines storage and the management of controlled drugs.

One area for improvement was identified in relation to the completion of medicine administration records.

Following discussion with two residents and observation of other residents we noted that they were relaxed and comfortable in their environment.

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	1

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Assumpta McKeown, Deputy 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.

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 undertaken on 30 January 2018. 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; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

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

During the inspection the inspector met with two residents, two staff, the deputy manager and the registered manager.

Ten questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of
- 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 30 January 2018

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 20 April 2016

Areas for improvement from the last medicines management inspection		
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 6 **Stated:** First time	The management of distressed reactions should be reviewed to ensure that where medicines are prescribed on a "when required" basis, a care plan is maintained and the reason for and the outcome of each administration is recorded.	**Met**
	Action taken as confirmed during the inspection: A small number of residents were prescribed medicines to manage distressed reactions; but were rarely required. Care plans were maintained. Staff confirmed that if administered, the reason for and outcome of administration were recorded in the comments section of the medicine administration records.	
Area for improvement 2 **Ref**: Standard 6 **Stated:** First time	Each resident should have their pain management detailed in a care plan.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of care plans indicated that pain management was included.	

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 staff. The impact of training was monitored through team meetings, supervision and annual appraisal. Refresher training in medicines management was provided every year. Other training included the management of swallowing difficulty. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

There were largely satisfactory procedures in place to ensure the safe management of medicines during a resident's admission to the home and for the management of medicine changes. Written confirmation of the resident's medicine regimes was obtained and personal medication records were updated by two members of staff. This safe practice was acknowledged. For one resident, it was noted that some external preparations were listed on the written confirmation list; however, were not held in stock and therefore were not being administered. Advice was given. The deputy manager gave assurances that she would contact the prescriber immediately after the inspection.

With the exception of the external preparations as detailed above, systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available. Staff advised of the procedures to identify and report any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay.

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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. A care plan was in place; the completion of a separate warfarin administration record was acknowledged.

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 every day.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of controlled drugs 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.

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. See records section below.

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.

The management of distressed reactions, pain and swallowing difficulty were examined. The relevant care plans and medicines records were in place. See also Section 6.2.

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.

Most of the medicine records were well maintained and facilitated the audit process. However, the completion of medicine administration records should be reviewed. The administration of a number of antibiotic doses and one weekly medicine had not been recorded. Whilst a review of the medicine containers indicated that the dose had been given, this suggests that staff were copying the medicine codes from the previous day on each occasion. The records should clearly state which medicine has been administered. An area for improvement was identified.

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

Following discussion with the deputy manager and staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to residents' healthcare needs.

Areas of good practice

There were some examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines. Staff were knowledgeable about the residents' medicines.

Areas for improvement

The administration of medicines should be reviewed to ensure that medicine administration records are fully and accurately maintained.

	Regulations	Standards
Total number of areas for improvement	0	1

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 was completed in a caring manner; residents were given time to take their medicines and medicines were administered as discreetly as possible.

The residents were observed to be content and comfortable in their environment. We met with two residents, who expressed their satisfaction with the staff and the care provided. They advised that they were administered their medicines on time and stated they had no concerns. Comments included:

“I enjoy being here.”
“I know all the staff well.”
“Good food; they know what I don’t like and give me something else.”
“I love it here; couldn’t have went to a better home.”

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. It was clear from discussion and observation of staff, that they were familiar with the residents’ likes and dislikes.

Of the ten questionnaires which were left in the home to receive feedback from residents and their representatives, ten were returned within the specified time frame (two weeks). The responses indicated that they were very satisfied with the care in the home. Two comments were made:

“Happy with care.”
“Care is good; no complaints.”

Any comments from residents and their representatives in questionnaires received after the return date will be shared with the manager for their information and action as required.

Areas of good practice

Staff listened to residents 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 create a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The inspector discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents. Staff confirmed that there were arrangements in place to implement the collection of equality data within Andena.

Written policies and procedures for the management of medicines were in place. These were not examined in detail. Staff advised that they were kept up to date regarding changes.

The management of medicine related incidents was reviewed. Staff confirmed that they knew how to identify and report incidents and advised of the procedures followed to ensure that all staff were made aware and to prevent recurrence. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

The deputy manager and staff advised of the auditing systems which were completed and how any areas for improvement were shared with staff.

Following discussion with the deputy 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 in relation to medicines management were raised with the management team. They advised that any resultant action was communicated through team meetings and supervision.

The staff spoke positively about their work and the working relationships in the home. They were very complimentary regarding the management team and advised that they felt well supported in their work. They stated they had no concerns.

One online questionnaire was completed by staff within the specified time frame (two weeks). The responses were recorded as very satisfied regarding the domains of safe, effective and compassionate care and the service being well led.

Areas of good practice

There were examples of good practice in relation to governance arrangements 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

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Assumpta McKeown, Deputy Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 11 July 2018	The registered person shall ensure that medicine administration records are fully and accurately maintained. Ref: 6.5
	Response by registered person detailing the actions taken: All medicine administration records are now fully and accurately maintained.

Please ensure this document is completed in full and returned via the Web Portal

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