Unannounced Medicines Management Inspection Report
20 April 2016

Andena

206-208 Ballymoney Road, Ballymena, BT43 5HG
Tel No: 028 2564 4767
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Andena took place on 20 April 2016 from 10.30 to 14.15.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

Is care safe?
No requirements or recommendations have been made.

Is care effective?
Two recommendations have been made.

Is care compassionate?
No requirements or recommendations have been made.

Is the service well led?
No requirements or recommendations have been made.

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	0	2

Details of the QIP within this report were discussed with Ms 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

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the most recent inspection on 15 December 2015.

2.0 Service details

Registered organisation/registered person: Mr James Joseph McConville	**Registered manager:** Mrs Christina Ann Shields
Person in charge of the home at the time of inspection: Ms Assumpta McKeown	**Date manager registered:** 1 April 2005
Categories of care: RC-DE, RC-I, RC-MP(E)	**Number of registered places:** 36

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home

Prior to the inspection, it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with two residents, one member of care staff, and one member of senior care staff.

The following records were 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 15 December 2015

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 15 May 2013

Last medicine management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	All medicines must be administered as prescribed. Medication administration records must be fully and accurately maintained.	**Met**
	Action taken as confirmed during the inspection: The outcomes of the audit trails performed at the inspection and by the staff, indicated medicines had been administered as prescribed. The administration records were well maintained.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** Second time	Medicines must be stored at the temperature specified by the manufacturer.	**Met**
	Action taken as confirmed during the inspection: A new medicine refrigerator had been obtained for the cold storage of medicines. Medicines were stored at the correct temperature.	
Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time	When the administration of topical medicines is delegated to other members of staff, a record training must be in place and a record of any administration maintained.	**Met**
	Action taken as confirmed during the inspection: There was evidence that care staff had received training in the management of external preparations. Records of the administration of these medicines were maintained and reviewed within the audit process.	

Requirement 4 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must closely monitor the administration of inhaled medicines. Any further discrepancies must be investigated and reported to RQIA.	**Met**
	Action taken as confirmed during the inspection: Examination of the audit records indicated that inhaled medicines were regularly audited. There was no evidence of any further discrepancies.	
Last medicine management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	The registered manager should further develop the audit process for medicines to ensure it covers all aspects of medicines management.	**Met**
	Action taken as confirmed during the inspection: The audit process had been reviewed and revised to ensure all areas of medicines management were included.	

4.3 Is care safe?

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 team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in general medicines management was 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.

There were satisfactory arrangements in place to manage changes to prescribed medicines. In accordance with best practice, staff were advised that on every occasion, two members of staff should initial the new medicine entries on the personal medication records. It was agreed that this practice would be implemented from the day of the inspection onwards.

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. Advice was given in relation to checks on other controlled drugs which do not require storage in the controlled drug cabinet.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts 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. Medicine refrigerators were checked at regular intervals.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

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.

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. A care plan was not maintained and the reason for and the outcome of the administration was not recorded. A recommendation was made. 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 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 pain, and for those that couldn't, staff were aware of now each resident would express their pain. It was recommended that a care plan in relation to pain management should be 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.

Medicine records were well maintained and facilitated the audit process. The good standard of record keeping was acknowledged.

Practices for the management of medicines were audited throughout the month by the staff and management. This included a focus on medicines which were not supplied in the 7 day or 28 day medicine packs. 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 were contacted in response to issues or concerns in relation to medicines management.

Areas for improvement

The management of distressed reactions should be reviewed to ensure that where medicines are prescribed on a "when required" basis, a detailed care plan is maintained and the reason for and the outcome of each administration is recorded. A recommendation was made.

The management of pain should be reviewed to ensure that where medicines are prescribed to treat pain, the resident's pain management is detailed in a care plan. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

Appropriate arrangements were in place to facilitate residents responsible for the self-administration of medicines.

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 spoken to at the inspection, advised that they had no concerns in relation to the management of their medicines, and their requests for medicines prescribed on a "when required" basis was adhered to e.g. pain relief.

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?

Written policies and procedures for the management of medicines were in place. 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 incidents. Staff confirmed that they knew how to identify and report incidents. There had been no medicine related incidents reported since the last medicines management inspection. Staff advised of the procedures in place to make staff aware of an incident and the corrective action taken.

A review of the internal audit records indicated that satisfactory outcomes had been achieved.

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 regarding medicines management were raised with management. They advised that any resultant action was communicated to staff at team meetings, supervision or individually with staff.

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

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Assumpta McKeown, Deputy Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. 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 person/s 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 DHSSPS Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to pharmacists@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the service. The findings set out are only 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 person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 21 May 2016	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.
	Response by registered person detailing the actions taken: We have included a Care Plan for Mood Altering Medication.
Recommendation 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 21 May 2016	Each resident should have their pain management detailed in a care plan.
	Response by registered person detailing the actions taken: We have commenced a Care Plan for all Pain Relief used.

The Regulation and Quality Improvement Authority

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