Unannounced Post-Registration Medicines Management Inspection Report
12 January 2018

The Cara

Type of service: Residential Care Home
Address: 114 Duneaney Road, Rasharkin, BT44 8SR
Tel No: 028 2957 1330
Inspector: Judith Taylor

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 provider 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 eight beds that provides care for residents over the age of 65 years.

3.0 Service details

Organisation/Registered Provider: Cara Care Home Ltd **Responsible Individual:** Mrs Elizabeth Kathleen Mary Lisk	**Registered Manager:** Mrs Linda Jamieson
Person in charge at the time of inspection: Mrs Linda Jamieson	**Date manager registered:** 12 June 2017
Categories of care: Residential Care (RC) I – Old age not falling within any other category	**Number of registered places:** 8 • a maximum of eight residents shall be accommodated in single bedrooms in the main home only • the chalet accommodation comprising three beds must not be used by residents until approval has been granted by RQIA • the home is approved to provide care on a day basis to 4 persons.

4.0 Inspection summary

An unannounced inspection took place on 12 January 2018 from 10.05 to 13.50.

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).

This was the first medicines management inspection since the registration of a new provider and manager in June 2017. The inspection sought 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 medicines administration, medicine records, storage and the management of controlled drugs.

One area requiring improvement was identified in relation to the management of distressed reactions.

Residents and relatives were complimentary regarding the care provided. There was a warm and welcoming atmosphere in the home.

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

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Linda Jamieson, 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.

4.2 Action/enforcement taken following the pre-registration inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 10 August 2017. No further actions were required to be taken following this inspection.

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 service was reviewed. This included the following:

- recent inspection reports
- recent correspondence with the home
- the management of incidents: it was ascertained that no incidents involving medicines had been reported to RQIA since the home re-registered

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

A total of ten questionnaires were provided for distribution to residents and their representatives. Staff were invited to share the views and opinions by completion of an online questionnaire.

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

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

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 10 August 2017

The most recent inspection of the home was an unannounced care inspection. There were no areas for improvement made as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection

This was the first medicines management inspection to the home since the registration of a new provider and manager.

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. A list of staff names and sample signatures and initials was in place. The impact of training was monitored through team meetings and supervision. There were procedures in place for staff appraisal and review of competency. Refresher training in medicines management was provided in the last year. Further training is planned in February 2018.

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. Antibiotics and newly prescribed medicines had been received into the home without delay.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two staff. This safe practice was acknowledged.

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. For one resident, written confirmation of their medicine regime had not been obtained. The registered manager advised that she would contact the prescriber to obtain this by the end of the day.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Staff were reminded that stock balances should be brought to zero when the complete supply of a controlled drug had been returned to the community pharmacy or transferred out of the home. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

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. Satisfactory systems were in place to store any medicines which required cold storage.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessments, the storage of medicines and controlled drugs.

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

With the exception of a few medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. Those medicines which required review were highlighted to the registered manager for close monitoring. For one medicine, the incorrect dose was being administered and it was agreed that the prescriber would be contacted.

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.

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 confirmed that they 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. A care plan detailing the parameters for administration was not in place; some information was recorded in protocols for "when required" medicines e.g. diazepam. These medicines were being administered; however, the reason for and the outcome of administration were not recorded. An area for improvement was identified.

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 the residents could tell staff if they were in pain and could ask for pain relief. There was some information in the resident's care plan. It was agreed that these would be further developed. A pain assessment tool was also available for use as needed.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicines which were not contained within the 28 day blister packs. Staff had also recorded the stock balance of medicines carried forward to the next medicine cycle. These records readily facilitated the audit process and this good practice was acknowledged. A quarterly audit was also completed by the community pharmacist.

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

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the standard of record keeping and the administration of medicines. Staff were knowledgeable regarding the residents' medicines.

Areas for improvement

The management of distressed reactions should be reviewed to ensure that a detailed care plan is maintained and details of the reason for and outcome of each administration are clearly recorded.

	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 was not observed at this inspection.

Following discussion with staff, they confirmed that the residents were given plenty of time to swallow their medicines. They provided examples of when medicines were administered at a later or earlier time to facilitate the residents' preferences/needs; and confirmed that they were aware of and adhered to the prescribed time intervals between medicines.

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 the staff were familiar with the residents' likes and dislikes.

We acknowledged the warm and welcoming atmosphere in the home.

We met with two residents; they stated that they were happy in the home and could take their medicines. Comments included:
"The girls are very good."
"They would do anything for you."
"I am well cared for here."

The relative we met with spoke very positively about the care provided by staff and stated that "I couldn't ask for better."

All of the questionnaires which were left in the home to facilitate feedback from residents and their representatives were returned. The responses indicated that they were very satisfied/ satisfied with all aspects of the care provided. A few comments were made:
"I feel the care meets my (relative) needs, I have no concerns."
"Can be a bit understaffed at times."

These comments were shared with the registered manager for her attention and also with the care inspector.

Areas of good practice

There was evidence that staff listened to residents and relatives 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 creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Written policies and procedures for the management of medicines were in place. These had been signed by staff to indicate that they read and understood them. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them.

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 that medicine incidents may need to be reported to the safeguarding team.

An effective auditing system was in place. Staff advised of the procedures which would be followed if a discrepancy or an area for improvement was identified.

Following discussion with the registered manager and 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 management. They advised that there were effective communication systems in the home and that any resultant action was communicated to them at verbal and handwritten shift handover and at team meetings.

At the time of issuing this report, three staff had completed the online questionnaire. Their responses indicated they were very satisfied regarding the four domains of safe, effective and compassionate care and the service being well led.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, the management of medicine incidents 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 Linda Jamieson, Registered 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 6 **Stated:** First time	The registered person shall review the management of distressed reactions to ensure that a detailed care plan is maintained; and the reason for and outcome of any administration is clearly recorded. Ref: 6.5
To be completed by: 12 February 2018	**Response by registered person detailing the actions taken:** Elizabeth Lisk All PRN medication has been added to care plan, with reason for administration and outcome. A PRN medication book explaining the reason and outcome of PRN medication has been put in place for staff use and this will still be accompanied with PRN record sheets for Diazapam etc. All PRN pain relief will be recorded as well in the same way, except these will also be accompanied by PRN sheets and the Abbey pain scale.

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

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