Unannounced Medicines Management Inspection Report
11 April 2016

Glens

63 Middlepark Road, Cushendall, BT44 0SQ
Tel No: 028 2177 1588
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Glens took place on took place on 11 April 2016 from 10.30 to 13.30.

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?
One recommendation has 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	3

The details of the QIP within this report were discussed with Ms Geraldine Magee, 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 on 9 February 2016.

2.0 Service details

Registered organisation/registered person: Ms Paula Magee	**Registered manager:** Ms Geraldine Magee
Person in charge of the home at the time of inspection: Ms Geraldine Magee	**Date manager registered:** 1 April 2005
Categories of care: RC-I, RC-MP, RC-MP(E), RC-PH, RC-PH(E)	**Number of registered places:** 16

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 one resident and one member of 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 9 February 2016

The most recent inspection of the home was an unannounced care inspection. No requirements or recommendations were made as a result of the inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 7 June 2013

There were no requirements made as a result of the last medicines management inspection.

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 32 **Stated:** Second time	Stock balance checks on Schedule 2 and Schedule 3 controlled drugs should be performed and recorded at each handover of responsibility.	**Met**
	Action taken as confirmed during the inspection: Schedule 2 and Schedule 3 controlled drugs were checked at each handover of responsibility.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. Training was provided by the community pharmacist. In addition the registered manager had introduced e-learning training for staff; this included awareness of medicines, diabetes, Parkinson's, dementia, influenza, safe guarding and palliative care. 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.

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 largely satisfactory arrangements in place to manage changes to prescribed medicines. However, updates to personal medication records were not signed by two members of trained staff to ensure the accuracy of the entry. 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. The pages were not numbered. The registered manager advised that this would be addressed. 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 within the audit process which is good practice.

The management of high risk medicines should be reviewed e.g. warfarin. Written confirmation of warfarin dosage regimes was not obtained; dosage regimes were telephoned to the staff; however, the information was not verified by another member of staff. Advice was given in relation to safe practice. A daily stock balance check was not maintained. A recommendation was made.

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 at daily intervals. Some ice had formed and registered manager confirmed that it was due for defrosting. Oxygen was held in stock and signage was in place. It was agreed that the oxygen cylinder would be secured to the wall.

Areas for improvement

The management of warfarin should be reviewed to ensure that written confirmation of dosage regimes are obtained; if this is not possible, telephoned directions should be confirmed by two members of trained staff. A stock balance should be maintained each day. A recommendation was made.

Number of requirements	0	Number of recommendations	1

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, a care plan was not maintained. Records indicated that these medicines may be administered on a regular basis. The reason for and the outcome of administration were 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.

With the exception of one controlled drug patch, the sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. The non-administration of this patch was discussed in relation to administration and pain control with the registered manager. It was ascertained that the resident's pain control requirements had been met by the administration of break through analgesia. Advice was given. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. Staff advised that all of the residents could verbalise any pain, and a pain tool was available if necessary. A care plan was not maintained. A recommendation was made. A pain assessment was not always completed for new residents admitted to the home. It was agreed that this would occur for any new residents.

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.

Practices for the management of medicines were audited by the staff and management.

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 medicine related concerns or queries.

Areas for improvement

The management of medicines which are prescribed on a 'when required' basis for distressed reactions should be reviewed to ensure that a care plan is maintained, details of the reason for and the outcome of the administration are recorded and any increase in frequency or regular administration should be reported to the prescriber. A recommendation was made.

A care plan should be maintained for any resident prescribed medicines to control pain. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

The administration of medicines was not observed at this inspection. Following discussion with the registered manager, staff and resident, it was confirmed that 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 resident spoken to advised that they had no concerns in relation to the management of their medicines, and that staff responded to any request for medicines prescribed on a 'when required' basis e.g. pain relief.

There was evidence that some medicines were administered with yoghurt to help the resident swallow their medicines. It was agreed that this arrangement would also be recorded in the resident's care plan and pharmaceutical advice would be sought regarding the suitability of adding medicines to food.

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. The registered manager confirmed that these would be updated in relation to warfarin. Staff advised that they were familiar with the policies and procedures and that any updates were highlighted at team meetings and supervision.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents and advised of the procedures taken to ensure that all staff were made aware of incidents and the corrective action taken.

A review of the internal audit records indicated that satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the staff, it was evident that they 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 any resultant action was communicated with staff at the time and also via team meetings.

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 Geraldine Magee, Registered 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 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 person/manager 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 person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 12 May 2016	The management of warfarin should be reviewed to ensure that robust procedures are in place. **Response by registered person detailing the actions taken:** management of warfarin has been reviewed – written confirmation of warfarin dosages is now obtained and verified by record sheet monitor. Both bloods now monitored
Recommendation 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 12 May 2016	Where medicines are prescribed for the management of distressed reactions on a 'when required' basis, a care plan should be in place and details of the reason for and the outcome of administration should be recorded on every occasion; any regular administration should be reported to the prescriber. **Response by registered person detailing the actions taken:** Care plan now in place where residents receive medicines for the management of distressed reactions on a when required basis and regular administration will be reported
Recommendation 3 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 12 May 2016	Where residents are prescribed medicines to manage pain, this should be recorded in the care plan. **Response by registered person detailing the actions taken:** Care plan now include pain management for all resident.

REGULATION AND QUALITY
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12 MAY 2016

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