Announced Medicines Management Inspection Report
17 May 2017

Carn-vaddy

Type of service: Residential Care Home
Address: 15 Doctors Road, Ballymena, BT42 4HL
Tel No: 028 2563 2678
Inspector: Judith Taylor

1.0 Summary

An announced inspection of Carn-vaddy took place on 17 May 2017 from 10.50 to 11.50.

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. One area was identified for improvement in relation to residents accommodated for a period of respite care. One recommendation was made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure residents were receiving their medicines as prescribed. One area of improvement was identified in relation to record keeping and audit; one requirement was made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be caring and timely which promoted the delivery of positive outcomes for residents. The resident 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 incidents or errors relating to medicines. No requirements or recommendations were 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	1	1

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

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 12 January 2017.

2.0 Service details

Registered organisation/registered person: Mrs Margaret Magee	**Registered manager:** Mrs Margaret Magee
Person in charge of the home at the time of inspection: Mrs Margaret Magee	**Date manager registered:** 1 April 2005
Categories of care: RC-I, RC-LD, RC-LD(E)	**Number of registered places:** 3

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, one member of staff and the registered manager.

Ten questionnaires were issued to staff, residents and their relatives/representatives, with a request that these be completed and returned to RQIA within one week of 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
- policies and procedures
- care plans
- training records

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 12 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 1 October 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The registered manager must make the necessary arrangements to ensure that personal medication records are fully and accurately maintained at all times.	**Met**
	Action taken as confirmed during the inspection: A personal medication record was maintained for each resident; the date of writing and drug allergy status were recorded. One prescribed medicine was not recorded for a new resident and it was agreed that this would be added later on the day of the inspection.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must ensure that written confirmation of medicine regimes is obtained for each new resident.	**Met**
	Action taken as confirmed during the inspection: The management of medicines for two new residents was reviewed. Written confirmation was received for one resident and for the other resident this was confirmed by telephone. Advice was given. The registered manager advised that written confirmation would be obtained for all new residents. Due to the progress made and assurances provided, this requirement has been assessed as met.	

Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must ensure that a record of incoming medicines is maintained on every occasion.	**Met**
	Action taken as confirmed during the inspection: These records were well maintained for two of the three residents. When medicines were supplied for a resident receiving respite care, a record had not been maintained. The need for this was highlighted. The registered manager advised that this would be addressed. Due to the progress made and assurances provided, this requirement has been assessed as met.	
Requirement 4 **Ref**: Regulation 19(2) **Stated:** First time	The registered manager must ensure that records of staff training and competency in the management of medicines are maintained.	**Met**
	Action taken as confirmed during the inspection: There were records in place which demonstrated that staff had received medicines management training recently. Competency was assessed through appraisal.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 30 **Stated:** Second time	The registered manager should further develop the written policies and procedures to ensure these cover all aspects of the management of medicines.	**Met**
	Action taken as confirmed during the inspection: Medicines management policies and procedures had been further developed. The most recent review was in August 2016.	

4.3 Is care safe?

Medicines were usually administered by the registered manager. She advised that all staff administering medicines were trained and deemed competent to do so. Training had been provided in February 2017 and competencies were assessed through review of records and staff appraisal.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. The registered manager 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. Personal medication records were updated by two members of staff. This safe practice was acknowledged.

The management of new residents' medicines was examined. Written confirmation of medicine regimes was received if the resident was discharged from hospital. This did not occur for one resident who was accommodated for a period of respite care. However, it was acknowledged that the registered manager had contacted the resident's prescriber to check the medicines. The need for a written list was emphasized. A recommendation regarding respite care was made (see also Section 4.4).

It was noted that one controlled drug had recently been supplied. Staff were not aware that this was a controlled drug which required safe custody. This was put in the controlled drug cabinet at the inspection and it was agreed that stock reconciliation checks at each shift change, would commence from the day of the inspections onwards.

Robust arrangements were observed for the management of high risk medicines.

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.

Areas for improvement

The management of medicines in relation to residents accommodated for a period of respite care should be reviewed to ensure that robust arrangements are in place. A recommendation was made.

Number of requirements	0	**Number of recommendations**	1

4.4 Is care effective?

With the exception of a few medicines, the medicines were supplied in seven day blister packs or 28 day monitored dosage system sachets.

The audit trail on one medicine could not be concluded as the date of opening was not recorded and the previous records were not readily available. It could not be determined if the correct dose was being administered. The registered manager must investigate these observations and forward a report of the findings and action taken. A requirement was made.

Some of the medicine records were well maintained and facilitated the audit process. However, as stated in Section 4.2, improvements in the receipt of medicines for residents receiving respite care are necessary. A recommendation regarding respite care was made in Section 4.3. Staff were reminded that the reason for the disposal of medicines should be recorded on each occasion.

Staff knew that time critical medicines such as bisphosphonates must be administered separately from other medicines. They were reminded that the actual time of administration should be recorded and advice was given.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff advised that the residents could tell staff if they were in pain.

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 when this had occurred.

Following discussion with the registered manager, it was evident that when applicable, other healthcare professionals were contacted in response to the resident's health care needs.

Areas for improvement

The registered manager must investigate the observations made in one identified medicine and report the findings and action taken. A requirement was made.

Number of requirements	1	**Number of recommendations**	0

4.5 Is care compassionate?

The administration of medicines was not observed during this inspection.

The registered manager confirmed that the residents were encouraged to take their medicines and there was good compliance with medicine regimes.

The resident we spoke with had no concerns regarding the management of medicines or their care in the home.

As part of the inspection process questionnaires were issued to residents, their representatives and staff. No questionnaires had been returned at the time of issuing this report.

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.

There were systems to manage any medicine related incidents. The registered manager advised that none had occurred. She confirmed that staff were aware that incidents may need to be reported to the safeguarding team and that training had been provided in March 2017.

The auditing arrangements for medicines were reviewed. The registered manager stated that all medicines were reviewed as part of the monthly ordering process. She confirmed that this would highlight any medicine discrepancies. It was suggested that the date of opening should be recorded and a running stock balance should be maintained for any medicines which were not supplied in the monitored dosage systems/blister packs.

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 Margaret Magee, 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 **RQIA's office** 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:** 17 June 2017	The registered provider must investigate the observations made in one identified medicine and forward a written report of the findings and action taken to RQIA. **Response by registered provider detailing the actions taken:** SEE ATTACHED REPORT.
Recommendations	
Recommendation 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 17 June 2017	The registered provider should review the medicines management systems for residents accommodated for respite care, to ensure robust systems are in place. **Response by registered provider detailing the actions taken:** Reviewed systems now in place to ensure medicines for respite residents are entered.

CARN-VADDY P.R.H.

RE. MEDICINES INSPECTION.

THIS MEDICINE WAS ORDERED BUT WAS ON ANOTHER SCRIPT BECAUSE THE MEDICINE WAS NOT DUE UNTILL THE FOLLOWING WEEK. THE SCRIPT WAS FILLED AND MEDICINE RECORDED AS RECEIVED. THE PREVIOUS ENTRY WAS DELETED IN MEDICINE BOOK AS ENTERED IN ERROR. THIS MEDICINE IS NOW ENTERED SEPARATELY IN MEDICINE BOOK.

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