Unannounced Medicines Management Inspection Report
10 April 2018

Ard Na Grainde

Type of service: Residential Care Home
Address: 15 Moneyrod Road, Randalstown, BT41 3JB
Tel No: 028 9447 3089
Inspector: Rachel Lloyd

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 19 beds that provides care for residents with a variety of care needs as detailed in section 3.0.

3.0 Service details

Organisation/Registered Provider: Ard Na Grainde **Responsible Individual:** Mr Justin McCann	**Registered Manager:** Mr Justin McCann
Person in charge at the time of inspection: Mr Justin McCann	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC): DE – Dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years I – Old age not falling within any other category A – Past or present alcohol dependence	**Number of registered places:** 19 including: 5 named individuals with mild and moderate dementia

4.0 Inspection summary

An unannounced inspection took place on 10 April 2018 from 10.35 to 13.05.

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 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 medicines administration, most medicine records, medicine storage and the management of controlled drugs.

One area for improvement was identified in relation to the management of medicines prescribed for use “when required” for the management of distressed reactions.

There was a warm and welcoming atmosphere in the home. Residents were relaxed and good relationships with staff were evident.

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 Mr Justin McCann, 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 most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 23 January 2018. Other than those actions detailed in the QIP no further actions were required to be taken. 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 home's registration

During the inspection the inspector met with three residents, one relative, one member of administrative 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 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
- medicines storage temperatures

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 23 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 25 May 2016

There were no areas for improvement identified as a result of the last medicines management inspection.

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 care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, discussion and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was provided in October 2017. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

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. All medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

Arrangements were in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. This safe practice was acknowledged. However, some recent changes in formulation of prescribed medicines e.g. liquid to tablet, had not been updated on personal medication records, the registered manager agreed to address this following the inspection.

There were procedures in place to ensure the safe management of medicines during a resident's admission to 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.

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. It was acknowledged that medicine storage areas were clean, tidy and organised although limited in terms of storage and workspace. However, since the number of registered beds in the home has increased significantly since the last inspection, it was advised that consideration should be given to reviewing the storage of medicines. A medicines trolley or a relocation of the medicine storage area would be more suitable, particularly once the home is full. The registered manager agreed to review this following the inspection. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Medicines requiring cold storage were stored securely in the kitchen refrigerator and medicine storage temperatures were checked at regular intervals.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, the management of medicines on admission, the management of controlled drugs and the secure storage of medicines.

Areas for improvement

No areas for improvement were identified.

	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.

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 or three monthly medicines were due.

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 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. However, the reason for and the outcome of administration were not recorded and a resident specific care plan was not in place. 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 any pain was well controlled and the resident was comfortable. Staff advised that most of the residents could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment is completed as part of the admission process.

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 would be reported to the prescriber.

Medicine records were mostly well maintained and readily facilitated the audit process.

Practices for the management of medicines were audited throughout the month. This included maintaining running stock balances for all medicines. A medicines governance audit was completed annually, to review systems and procedures.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to the needs of the residents.

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.

Areas for improvement

When a resident is prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the circumstances when this may be administered should be detailed in the care plan and the reason for and outcome of each administration should be 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 to residents was not observed during this inspection. Following discussion with staff it was confirmed that residents were given time to take their medicines and medicines were given in accordance with the residents' preferences.

Throughout the inspection, good relationships were observed 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' backgrounds and their likes and dislikes. Residents who could not verbalise their

feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

The residents and relative spoken to advised that they were content with the management of medicines and the care provided in the home. They were complimentary regarding staff and management. Comments made included:

"This is a family home, unlike other care homes; my relative is treated like part of the family."
"I am very well looked after, I've been asked if I want to go home, but I want to stay here."
"I'd rather be here than anywhere else."

Ten questionnaires were left in the home to facilitate feedback from residents and relatives. None were returned within the specified timescale (two weeks).

Any comments from residents, their representatives or staff received after the issue of this report will be shared with the registered manager for their information and action as required.

Areas of good practice

There was evidence that 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 creates 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. The equality data collected was managed in line with best practice

Written policies and procedures for the management of medicines were in place. Following discussion with staff it was evident that they were familiar with these.

There were arrangements in place for the management of any 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.

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

Following discussion and observation, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with management. They stated that there were good working relationships.

No members of staff shared their views by completing the online questionnaire prior to the issue of this report.

Areas of good practice

There were examples of good practice found throughout the inspection 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 Mr Justin McCann, 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 the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 10 **Stated:** First time **To be completed by:** 10 May 2018	The registered person shall ensure that when a resident is prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the circumstances when this may be administered are detailed in the care plan and the reason for and outcome of each administration is recorded. Ref: 6.5
	Response by registered person detailing the actions taken: The home has documented in clients care plans and daily care notes if medication is required for distressed reactions and the outcome post administration .

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews