Unannounced Medicines Management Inspection Report
6 November 2018

Hollybank

Type of service: Residential Care Home
Address: 13 Union Road, Magherafelt, BT45 5DF
Tel No: 028 7963 3369
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 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 nine beds that provides care for residents living with care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Northern HSC Trust **Responsible Individual:** Dr Anthony Baxter Stevens	**Registered Manager:** Miss Cecelia Donnelly
Person in charge at the time of inspection: Ms Betty McGarry (Senior Support Worker)	**Date manager registered:** 18 December 2017
Categories of care: Residential Care (RC) LD – Learning disability LD(E) – Learning disability – over 65 years	**Number of registered places:** 9

4.0 Inspection summary

An unannounced inspection took place on 6 November 2018 from 10.35 to 13.45.

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 during and 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 training, the administration of medicines and the storage arrangements for medicines.

Three areas for improvement in relation to record keeping and governance arrangements for medicines management were identified.

Residents were observed to be relaxed and comfortable in their surroundings and we noted the 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	3

Details of the Quality Improvement Plan (QIP) were discussed with Ms Betty McGarry, Senior Support Worker, as part of the inspection process. The timescales for completion commence from the date of the inspection. Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the care inspection undertaken on 11 September 2018. 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 medicines related incidents reported to RQIA since the last medicines management inspection

A poster was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

During the inspection we met with one resident, one member of care staff and the person in charge.

We provided 10 questionnaires to distribute to residents and their representatives, for completion and return to RQIA and we asked staff to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

A sample of the following records was examined during the inspection:

- medicines received
- personal medication records
- medicine administration records
- medicines transferred
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

We left 'Have we missed you?' cards in the home to inform residents and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

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 11 September 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 9 June 2016

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 6 **Stated:** First time	Detailed care plans for the management of distressed reactions should be in place where applicable.	**Met**
	Action taken as confirmed during the inspection: There was evidence that care plans regarding the management of distressed reactions were in place.	
Area for improvement 2 **Ref:** Standard 6 **Stated:** First time	Detailed care plans for the management of pain should be in place where applicable.	**Met**
	Action taken as confirmed during the inspection: There was evidence that pain management was included in the resident's care plans.	

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 new staff. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was provided each year. Other training included the management of swallowing difficulty, enteral feeding and epilepsy. A training matrix was maintained. Staff were reminded that additional medicine related training such as oxygen management and diabetes awareness should be recorded.

The process for the supply of medicines was reviewed. Medicines were supplied by the resident's family at the time of admission. Staff provided details of the processes to ensure that up to date medicines information was obtained at or prior to the period of short break care, including the management of any medicine changes since the last admission. However, we noted four medicines which were recorded on the residents' personal medication records (PMR) but were not held in stock. The person in charge advised that any differences in PMRs and medicines supplied should have been identified and followed up, and advised this would be addressed with immediate effect. A robust system to correlate personal medication records with medicine supplies at the time of admission should be implemented. An area for improvement was identified.

In relation to safeguarding, staff were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed.

Largely satisfactory arrangements were in place for the management of controlled drugs. A controlled drug cabinet was available for use when required. There was no stock held at the time of the inspection. Records of the receipt, administration and transfer were recorded in a controlled drug record book. Staff were reminded that each page should be numbered and when the complete supply of controlled drug is returned to family, the stock balance should be brought to zero.

Epilepsy management plans were located in the care files and medicine folders.

Any medicines remaining at the end of the period of short break care were returned to the resident's family.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment and the storage of medicines.

Areas for improvement

The admission process for medicines should be reviewed to ensure that personal medication records are checked against the medicines supplied and any discrepancies followed up.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

The management of pain was discussed. Staff advised that analgesia was occasionally administered and was discussed as part of the resident's admission process. Staff advised that they were aware of how each resident would express/communicate pain.

The management of distressed reactions was reviewed. The medicine and dosage directions were clearly recorded on the resident's personal medication record. Residents rarely required these medicines; however, when administered this was discussed with the resident's family and details recorded.

The management of swallowing difficulty was examined. The thickening agent was recorded on the residents' personal medication records and care files. Speech and language assessment reports were in place.

Some residents were required to be administered nutrition, fluids and medicines via the enteral route. The care plan and feeding regime were in place. The enteral feed was not recorded on the personal medication record and detailed records of the administration of enteral feeds, including all flushes with water were not maintained. The need for this was discussed in relation to ensuring the daily fluid intake was totalled each day and to ensure the target volume of fluid intake had been achieved. Advice was given. An area for improvement was identified.

Staff stated 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 family and prescriber.

We reviewed a variety of medicine records. Records of the receipt, administration and transfer of medicines were well maintained. However, we observed that a small number of personal medication records required some further information in relation to the strength of the medicine, the dose and the resident's allergy status. This should be monitored as part of the audit process. An area for improvement in relation to audit was made in Section 6.7.

Areas of good practice

There were examples of good practice in relation to the administration of medicines, care planning and the completion of most records.

Areas for improvement

The record keeping in relation to enteral feeding should be reviewed and revised.

	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 the time of this inspection. Staff advised that the residents were given time and encouraged when applicable to take their medicines. It was evident that the staff were familiar with how each resident liked to take their medicines.

We noted the warm and welcoming atmosphere in the home. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was clear from observation of staff, that they were familiar with the residents' likes and dislikes.

We met with residents before they left for a bus trip and briefly chatted to one resident. The residents were observed to relaxed and comfortable in their environment and in their interactions with staff. It was not possible to obtain the residents views or opinions regarding their care.

Of the questionnaires that were issued, one was returned within the specified time frame (two weeks). The responses indicated that they were very satisfied with the care provided. Any comments from residents and their representatives in questionnaires received after the return date will be shared with the registered manager as required.

Areas of good practice

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.

We discussed the 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. Arrangements were in place to implement the collection of equality data within Hollybank.

Written policies and procedures for the management of medicines were in place. These were not examined in detail. The person in charge advised that these were in the process of being updated.

There were satisfactory arrangements in place for the management of medicine related incidents. Staff knew how to identify and report incidents to the relevant persons, including the safeguarding team. There were systems in place to ensure that staff were made aware of incidents, and to prevent recurrence.

The governance arrangements for medicines management were examined. Medicine audits were completed on tablets, capsules and sachets. A variety of medicines and medicine records should be audited. As there were some areas identified for improvement in the domains of safe and effective care, a detailed auditing process which encompasses all areas of medicines management should be developed and implemented. An area for improvement was identified.

Following discussion with the staff, it was evident that they 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 the registered manager and advised that there were effective communication systems in the home.

The staff we met with spoke positively about their work and it was clear that there were good working relationships in the home with staff and management. They stated that some staff had worked in the home for several years.

No online questionnaires were completed by staff with the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

The audit process for medicines management should be reviewed and revised to ensure it covers all aspects of medicines management.

	Regulations	Standards
Total number of areas for improvement	0	1

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 Ms Betty McGarry, Senior Support Worker, 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 30 **Stated:** First time **To be completed by:** 6 December 2018	The registered person shall review the admission process to ensure that personal medication records are checked against incoming medicines supplies and any discrepancies followed up. Ref: 6.4
	Response by registered person detailing the actions taken: Admissions process documentation has been developed to include the following: a) check medication provided by families corresponds with the Kardex; b) check all medication recorded on the Kardex is supplied at time of admission and if not ascertain and record reasons why; c) Check enteral feeds and flushes are included on the Kardex (where required; d) Note action taken regarding any discrepancies; e) Clairfy any specific instructions regarding PRN medication.
Area for improvement 2 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 6 December 2018	The registered person shall review the record keeping in relation to enteral feeding and fluid intake records. Ref: 6.5
	Response by registered person detailing the actions taken: As above, staff will ensure that enteral feed and required fluid intake is included on the Kardex. Enteral feed and fluid balance recording sheets have been developed and are in use to record amount of feed and fluid given to the service user and are totalled at the end of each day to ensure amount corresponds with feeding regime.
Area for improvement 3 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 6 December 2018	The registered person shall further develop the audit process to ensure that it covers all aspects of medicines management. Ref: 6.7
	Response by registered person detailing the actions taken: New audit sheet has been developed to cover all aspects of medicines management.

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

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