Unannounced Medicines Management Inspection Report
9 June 2016

Hollybank

Type of Service: Residential Care Home
Address: 13 Union Road, Magherafelt, BT45 5DF
Tel No: 028 7963 3369
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Hollybank took place on 9 June 2016 from 10:20 to 12:30.

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 two areas for improvement was identified and are set out in the quality improvement plan (QIP) within this report.

Is care safe?
No requirements or recommendations were made.

Is care effective?
Two recommendations regarding the management of distressed reactions and pain were made.

Is care compassionate?
No requirements or recommendations were made.

Is the service well led?
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	0	2

Details of the QIP within this report were discussed with Ms Cecelia Donnelly, Deputy 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 previous QIP there were no further actions required to be taken following the last inspection on 13 December 2015.

2.0 Service details

Registered organisation/registered person: Northern HSC Trust Dr Anthony Baxter Stevens	**Registered manager:** Mrs Arlene Elizabeth Stewart
Person in charge of the home at the time of inspection: Ms Cecilia Donnelly (Deputy Manager)	**Date manager registered:** 1 April 2005
Categories of care: RC-LD, RC-LD(E)	**Number of registered places:** 9

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection

We met with one resident and three members of staff.

A sample of the following records was examined:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- 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 care inspection dated 13 December 2015

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 14 August 2014

Last medicines management inspection recommendation		Validation of compliance
Recommendation 1 **Ref:** Standard 32 **Stated:** First time	The registered manager should ensure that the temperature of the office is monitored and recorded each day to confirm that it is maintained at or below 25°C.	**Met**
	Action taken as confirmed during the inspection: The temperature of the office where medicines are stored is now monitored and recorded each day; satisfactory readings were observed.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. The deputy manager advised that senior carers attend training which is provided by the trust every two years. Training on the management of medicines had been provided by the community pharmacist recently. The impact of training was monitored through team meetings, supervision and annual appraisal. Refresher training on the management of enteral feeding and epilepsy was provided.

Medicines were supplied by and returned to family or carers on admission and discharge from the home. Staff advised of the procedures to identify and prevent shortfalls in medicines.

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 for each period of respite care. There were satisfactory arrangements in place to manage changes to prescribed medicines in between and during periods of respite care. A personal medication record was in place for each resident. Prior to each period of respite care families are issued with a blank personal medication record so that if there have been any medication changes it can be rewritten by the prescriber. The medicines received are checked against the personal medication record at the beginning of each period of respite care; staff advised that any anomalies would be followed up.

Mostly satisfactory arrangements were observed for the management of high risk medicines e.g. buccal midazolam, rectal diazepam and medicines via the enteral route. It was agreed that a revised system for recording the administration of each medicine and all fluids via the enteral route would be developed and implemented; this will ensure that the required fluid intake is achieved each day.

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. Medicine refrigerators were checked when in use.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.4 Is care effective?

All medicines examined had been administered in accordance with the prescriber's instructions.

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 care plans were not in place. The reason for and the outcome of administration were recorded in the care notes. A recommendation was made.

The deputy manager advised that residents were not prescribed controlled drugs to manage their pain. She advised that pain would be discussed at each admission and that staff were familiar with how each resident expressed their pain and were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. However care plans providing this detail were not in place. A recommendation was made.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Care plans and speech and language assessment reports were in place. However, each administration was not recorded. It was agreed with the deputy manager that each administration would be recorded in the daily diet sheets from the day of the inspection onwards. No further action is required.

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 families and/or prescriber.

Medicine records were well maintained and facilitated the audit process.

Practices for the management of medicines were audited throughout the month by both staff and management. This included twice daily stock counts on all medicines. Medicines were also reconciled at the end of each period of respite care. This practice facilitates identification of any errors and immediate corrective action; staff were commended for their efforts.

Following discussion with the deputy manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas for improvement

Detailed care plans for the management of distressed reactions should be in place where applicable. A recommendation was made.

Detailed care plans for the management of pain should be in place where applicable. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

The deputy manager 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. It was not possible to see a medicine round as four of the five residents had gone on a day trip and were not due back until early evening.

One resident who could not verbalise their feelings in respect of their care was observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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. Management advised that these were reviewed regularly. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents.

A review of the home's audit records indicated that largely 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 deputy manager and care 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 any resultant action was communicated with all staff either individually or via staff 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 Cecelia Donnelly, Deputy 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 6 **Stated:** First time **To be completed by:** 11 July 2016	Detailed care plans for the management of distressed reactions should be in place where applicable.
	Response by registered person detailing the actions taken: This is now included in the In-house care plan for each service user for whom this is relevant
Recommendation 2 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 11 July 2016	Detailed care plans for the management of pain should be in place where applicable.
	Response by registered person detailing the actions taken: This is now included in the In-house care plan for each service user for whom this is relevant

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address

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