Unannounced Medicines Management Inspection Report
5 April 2017

Lisgarel

Type of service: Residential Care Home
Address: Gloucester Park, Larne, BT40 1PD
Tel No: 028 2827 4833
Inspector: Rachel Lloyd

1.0 Summary

An unannounced inspection of Lisgarel took place on 5 April 2017 from 10.10 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.

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 systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. There were no areas for improvement identified.

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. There were no areas for improvement identified.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for residents. Residents spoke positively of their care in the home and the management of their medicines. There were no areas for improvement identified.

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. There were robust systems to manage and share the learning from medicine related incidents and areas identified within the audit process. There were no areas for improvement identified.

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	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mr Andrew Jamison, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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: Northern Health and Social Care Trust/ Mr Anthony Baxter Stevens	**Registered manager:** Mr Andrew Jamison
Person in charge of the home at the time of inspection: Mr Andrew Jamison	**Date manager registered:** 17 August 2015
Categories of care: RC-I	**Number of registered places:** 40

3.0 Methods/processes

Prior to the 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

During the inspection the inspector met with two residents, two senior care assistants and the registered manager.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

Fifteen questionnaires were issued to residents, residents' relatives/representatives and staff, with a request that these were 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
- 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 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 their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 5 May 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	It is recommended that the reason for and the outcome of administration of medicines prescribed on a 'when required' basis for the management of distressed reactions are routinely recorded.	**Met**
	Action taken as confirmed during the inspection: This was recorded in the daily progress notes on most of the occasions examined. Staff were reminded that this should take place on every occasion. The registered manager agreed to discuss this with staff following the inspection. For this reason this recommendation was not stated for a second time.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. 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 for all senior care staff within the last three years.

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 safe systems in place for obtaining and storing prescriptions until they were dispensed.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were usually updated by two members of staff. Staff were reminded that all personal medication records and any new entries should be checked for accuracy and signed by two competent members of staff.

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. 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. 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 at regular intervals.

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?

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, 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. The reason for and the outcome of administration were usually recorded (see 4.2). A care plan was maintained.

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 the pain was well controlled and the resident was comfortable. Staff advised that most of the residents could verbalise any pain and knew how the residents would express pain. A care plan was maintained for those prescribed regular analgesia.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record. Details of the prescribed fluid consistency were usually stated. The senior care assistant agreed to ensure this was recorded for all relevant residents. A care plan and speech and language assessment report was in place. There was also a reference point in the dining area to ensure that the prescribed details were readily available for staff.

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 throughout the month. In addition, a regular audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to matters relating to medicines management.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.5 Is care compassionate?

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 residents spoken to at the inspection stated that they were content with their care in the home and had no concerns regarding the management of their medicines. They advised that staff usually responded in a timely manner to any requests for medicines e.g. pain relief.

As part of the inspection process, questionnaires were issued to residents, relatives/residents' representatives and staff. One staff questionnaire was returned within the specified timescale. Responses indicated that the member of staff had no concerns with the management of medicines in the home.

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. These were not examined. 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. One medicine related incident reported since the last medicines management inspection was discussed.

A review of the audit records indicated that satisfactory outcomes had been achieved. Staff advised of the procedures in place to ensure that appropriate action was taken should a discrepancy arise.

Following discussion with the registered manager and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. The registered manager confirmed that staff had received training on adult safeguarding and were aware that medication incidents may need to be reported to the adult safeguarding lead.

Staff confirmed that any concerns in relation to medicines management were raised with management and outcomes shared with staff. They stated that they had received the relevant training and that they were supported by management.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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