Unannounced Medicines Management Inspection Report
10 May 2017

Clonmore House

Type of service: Residential Care Home
Address: 22-28 Crossreagh Drive, Rathcoole, Newtownabbey BT37 9DY
Tel No: 028 9085 1153
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Clonmore House took place on 10 May 2017 from 10.10 to 13.50.

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 for improvement in relation to medicine changes was identified. 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. Areas of good practice were acknowledged. Some care plans in relation to medicines management were in place. Two areas of improvement were identified regarding thickening agents and care plans. Two recommendations were made.

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. The resident and relative consulted with, confirmed that they had no concerns regarding the management of medicines. They spoke positively about the staff and the care provided in the home. 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 medicine related incidents and medicine audit activity. 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	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Tracey McCartney, Acting 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 27 March 2017.

2.0 Service details

Registered organisation/registered person: Northern HSC Trust/ Dr Anthony Baxter Stevens	**Registered manager:** See below
Person in charge of the home at the time of inspection: Mrs Tracey McCartney	**Date manager registered:** Mrs Tracey McCartney – Acting Manager, no application required
Categories of care: RC-I	**Number of registered places:** 42

3.0 Methods/processes

Prior to inspection we analysed the following records:

- 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, one member of senior care staff, one resident's relative and the acting 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.

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
- care plans
- training records
- medicines storage temperatures

Fifteen questionnaires were issued to residents, their relatives/representatives and staff, with a request that these were completed and returned within one week of the inspection.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 27 March 2017

The most recent inspection of the home was an unannounced care inspection. A QIP was issued and this 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 dated 14 April 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	It is recommended that the registered person should ensure that a care plan is maintained for residents who are prescribed medicines for the management of pain, on a 'when required' basis.	**Met**
	Action taken as confirmed during the inspection: Pain management was detailed in the sample of care plans examined.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. Records of training and competency were maintained. Competency was assessed at least annually. The impact of training was monitored through team meetings, supervision and annual appraisal.

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. It was agreed that any prescription forms waiting for collection, would be stored securely.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. Antibiotics and new medicines had been received and commenced in a timely manner. However, updates to the resident's personal medication records were not signed and verified by two members of staff. This should be addressed to ensure safe practice. A recommendation was made.

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. In recent days, the staff had

been provided with incorrect medicines information for one resident. This had been readily identified and addressed in a timely manner.

Suitable systems were in place to manage the disposal of discontinued or expired medicines. 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, three times per day. These checks included other controlled drugs, which is good practice.

The management of high risk medicines such as warfarin was examined. Staff confirmed that all warfarin dosages were received in writing and samples of these were provided. However, one current regime could not be located; it was agreed that this would be obtained from the prescriber after the inspection. The good practice of maintaining a separate administration record with a running stock balance was acknowledged. It was advised that when recording the new dose, this should be initialled by two staff to ensure accuracy in transcribing. This has been incorporated into a recommendation. It was advised that the residents' care plan should include a reference to warfarin. A recommendation regarding care plans was made in Section 4.4.

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.

Temperatures of medicine storage areas were monitored and recorded every day. The records of refrigerator temperatures indicated that the minimum temperature was sometimes below 2^{o}C. As there was no ice formed in this refrigerator and no evidence of excessively cold or wet stock, it was concluded that there may be a fault with the thermometer. The need to ensure that staff report any deviation in temperatures was discussed. The manager agreed to address this.

Areas for improvement

Any updates to the personal medication records and warfarin administration records should be signed and verified by two staff. A recommendation was made.

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

4.4 Is care effective?

With the exception of one liquid medicine, the sample of medicines examined had been administered in accordance with the prescriber's instructions. It was agreed that this medicine would be closely monitored from the day of the inspection onwards.

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, monthly or three monthly medicines were due.

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 for those that couldn't, they

provided examples of how this would be expressed by the resident. A care plan was maintained.

The management of medicines prescribed for distressed reactions was examined. 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 medicine details were recorded on the personal medication record. These medicines were rarely required to be administered; however, when administered there was evidence that staff had tried other interventions before administering the medicine. This is best practice and was acknowledged. The outcome of the administration was also recorded. A care plan was maintained; however, some further details should be included and were discussed with the staff and manager; this has been incorporated into a recommendation.

The management of swallowing difficulty for two residents was examined. Speech and language assessment reports and care plans were in place. The thickening agent and consistency level was recorded on one of the two personal medication records. This should be recorded for both residents. Records of administration were incomplete and one resident did not have their own supply. These issues were discussed and advice given. A recommendation was made.

One resident's care plan was reviewed in relation to the specific arrangements to manage the skin care. A detailed care plan should be in place. This was discussed with reference to the external preparations prescribed and self-administration as applicable. A recommendation was made.

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 the medicine formulation had been changed from tablets to liquid to assist swallowing and compliance.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included highlighting medicines such as bisphosphonates, antibiotics, controlled drugs, changes in dosages and medicines on hold. In addition, the staff recorded the date of opening of medicines and the date when the medicine was finished / required replacement, on the medicine administration records.

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

Areas for improvement

The residents' care plans should be updated to include the specific areas relating to medicines management. A recommendation was made.

The management of thickening agents should be reviewed to ensure that robust systems are in place. A recommendation was made.

Number of requirements	0	**Number of recommendations**	2

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.

Throughout the inspection, it was found that there were good relationships between the staff and the residents. Staff were noted to be friendly and courteous; they treated the residents with dignity.

Following discussion with the manager and staff, it was clear that they were familiar with the residents' needs, their likes and dislikes.

The resident spoken to had no concerns regarding the management of their medicines and advised that staff responded in a timely manner to any requests that they had.

The relative spoken to was very complimentary regarding the care provided in the home.

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.

As part of the inspection process, questionnaires were issued to residents, their relatives/representatives and staff. Three questionnaires were completed and returned. The responses were recorded as "very satisfied" 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?

Staff confirmed that written policies and procedures for the management of medicines were in place. These were not examined in detail. 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. They had been managed appropriately. In relation to the regional safeguarding procedures, staff confirmed that they were aware of what incidents may need to be reported to the safeguarding lead and safeguarding team.

A variety of internal auditing systems were in place for medicines management. They included daily, weekly and monthly audits. An overarching audit was completed by management and audits were completed by the community pharmacist. A review of the internal audit records indicated that largely satisfactory outcomes had been achieved. Where areas for improvement

had been identified, these were investigated and also raised at supervision and at team meetings.

Following discussion with the manager and staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. The staff confirmed that any concerns were raised with management. They spoke positively about their work and the good working relationships between the staff and other healthcare professionals.

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 Tracey McCartney, Acting 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 web portal 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

Recommendations	
Recommendation 1 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 10 June 2017	The registered provider should ensure that all updates to personal medication records and warfarin administration records involves two staff, and both sign the entry.
	Response by registered provider detailing the actions taken: This issue was addressed at a senior staff team meeting
Recommendation 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 10 June 2017	The registered provider should ensure that residents' care plans are updated in relation to medicines management.
	Response by registered provider detailing the actions taken: This issue was addressed at a senior staff team meeting
Recommendation 3 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 10 June 2017	The registered provider should review the management of thickening agents to ensure that robust arrangements are in place.
	Response by registered provider detailing the actions taken: The management of thickening agents was reviewed, new recording procedure was discussed and a new plan put in place

Please ensure this document is completed in full and returned to RQIA web portal

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