Unannounced Medicines Management Inspection Report
10 August 2018

Joymount House

Type of service: Residential Care Home
Address: Joymount Court, Carrickfergus, BT38 7DN
Tel No: 028 9336 3904
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 40 beds that provides care for residents living with 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:** Ms Gillian McBride
Person in charge at the time of inspection: Ms Gillian McBride	**Date manager registered:** 18 April 2014
Categories of care: Residential Care (RC) DE – Dementia I – Old age not falling within any other category	**Number of registered places:** 40

4.0 Inspection summary

An unannounced inspection took place on 10 August 2018 from 10.15 to 14.20.

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 competency assessment, management of new residents' medicines, medicine changes, the completion of most medicine records and the storage of medicines.

Areas for improvement were identified in the transcribing of medicines information and records regarding the administration of medicines for distressed reactions.

Residents were noted to be relaxed and content in the home. Those we met with spoke positively about their care and the staff.

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	2

Details of the Quality Improvement Plan (QIP) were discussed with Ms Gillian McBride, 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

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent care inspection on 5 June 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 medicine 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 the inspector met with five residents, two senior care staff and the registered manager.

We provided 10 questionnaires for distribution to residents and their representatives, for completion and return to RQIA.

We asked the registered manager 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
- controlled drug record book
- medicine audits
- 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.

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 5 June 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 August 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	The registered provider should review the management of pain to ensure that where medicines are prescribed to manage pain, this is referenced in a care plan. **Action taken as confirmed during the inspection**: There was evidence that pain management was referenced in the residents' care plans.	**Met**

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, supervision and annual appraisal. Competency assessments were completed annually. A sample of training records was provided. The registered manager advised that refresher training in medicines management was to be scheduled.

The management of new residents' medicines and medicines changes was examined. There were largely satisfactory arrangements in place. Written confirmation of medicine regimes and medicine changes was obtained and two staff were involved in updating personal medication records. This is safe practice. However, this did not occur when handwriting information on medication administration records. An area for improvement was identified.

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; however, advised of the difficulties in obtaining medicines for some residents in receipt of rehabilitation. They provided details of the actions taken to address this. Antibiotics and newly prescribed medicines had been received into the home without delay.

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. Additional checks were also performed on other controlled drugs which is good practice. We noted that the checks had been partially signed in advance for the 14.00 shift check; this was discussed and it was agreed that this practice would cease and the records would be completed at the actual time of the shift check only.

In relation to injections, these were administered by the community nurses and records of administration including the next due date of administration were maintained.

Appropriate arrangements were in place for administering medicines which were required to be crushed prior to administration.

Discontinued or expired medicines including controlled drugs were returned to the community pharmacy for disposal.

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. The medicine refrigerator temperatures were monitored and recorded every day.

Areas of good practice

There were examples of good practice in relation to competency assessment, the management of medicines on admission and the storage of medicines.

Areas for improvement

When transcribing information on medication administration records, two staff should be involved and both staff should sign the entry.

	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. 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 and a care plan was maintained. 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 not recorded. 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. Pain management was referenced in the resident's care plan. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. Staff advised that all of the residents could verbalise any pain.

The management of swallowing difficulty was examined for three residents. For those residents prescribed a thickening agent, this was recorded on their personal medication record; details of the fluid consistency were recorded for two residents. It was agreed that one resident's record would be updated after the inspection. Administration was recorded and care plans and speech and language assessment reports were in place.

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.

Most of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for antibiotics and recording the removal of 12 hour patches. The drug allergy status was not recorded on a few personal medication records for new residents and a small number of obsolete personal medication records remained in the current file. The registered manager gave an assurance that this would be addressed after the inspection.

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

Areas of good practice

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

Areas for improvement

The reason for and outcome of the administration of medicines to manage distressed reactions 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.

Appropriate arrangements were in place to facilitate residents responsible for the self-administration of medicines. A care plan was maintained.

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. It was clear from discussion and observation of staff, that they were familiar with the residents' likes and dislikes.

We noted that residents were relaxed and comfortable in their environment. We met with five residents, who spoke positively about the staff and the care provided. Comments included:

"Staff are A1."
"Everything is very good."
"If staff didn't give me my medicines, I would forget them."
"I am happy and have no complaints."
"I am not in pain and don't have pain."
"The food is no problem; plenty of food."
"I'm happy enough here."

Of the questionnaires which were distributed, none were returned from residents or their representatives within the specified time frame (two weeks). Any comments in questionnaires received after the return date will be shared with the registered manager as necessary.

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.

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. We were advised that there were arrangements in place to implement the collection of equality data within Joymount House.

Written policies and procedures for the management of medicines were in place. These were not examined.

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. 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.

The governance arrangements for medicines management were reviewed. Management advised of the daily and monthly audits which take place and how areas for improvement were identified and followed up. This was usually through meetings with staff. Also, as part of the pharmacist support to the home, a quarterly audit was undertaken and a list of the findings was left in the home for management to address. A sample of the internal audit outcomes was provided and these showed that largely satisfactory outcomes had achieved. However, it was noted that the audits were not being undertaken at monthly intervals as expected. The registered manager advised that she would review this.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities regarding medicines management. They confirmed that any concerns were raised with the registered manager; and any resultant action was discussed with them.

They spoke positively about their work and advised that there were good working relationships in the home with staff, management and with other healthcare professionals.

No online questionnaires were completed by staff within 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

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 Ms Gillian McBride, 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 with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 10 September 2018	The registered person shall ensure that two staff are involved in transcribing information on medication administration records and both staff sign the entry. Ref: 6.4
	Response by registered person detailing the actions taken: All kardex are signed by 2 staff. Staff have been reminded that all additions to the MRS must also be signed by 2 staff.
Area for improvement 2 **Ref**: Standard 8 **Stated:** First time **To be completed by:** 10 September 2018	The registered person shall ensure the reason for and the outcome of administration are recorded when medicines are administered to manage distressed reactions. Ref: 6.5
	Response by registered person detailing the actions taken: A separate template has been devised and added to the progress notes to make the recording of cause and effect for PRN medication and distressed reactions, easier to find and read.

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

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

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