Unannounced Medicines Management Inspection Report
25 August 2016

Joymount House

Type of service: Residential Care Home
Address: Joymount Court, Carrickfergus, BT38 7DN
Tel No: 028 9336 3904
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Joymount took place on 25 August 2016 from 09.55 to 13.25.

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. No requirements or recommendations were 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. One area of improvement was identified in relation to care plans and a recommendation was made. No requirements 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. Where possible residents were involved in the management of their medicines and there was evidence of self-administration. Residents spoke positively of their care in the home and the management of their medicines. 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. There were robust systems to manage and share the learning from medicine related incidents and areas identified within the audit process. 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	1

Details of the QIP within this report 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.

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 23 June 2016.

2.0 Service details

Registered organisation/ registered provider: Northern Health and Social Care Trust / Dr Anthony Baxter Stevens	**Registered manager:** Ms Gillian McBride
Person in charge of the home at the time of inspection: Ms Gillian McBride	**Date manager registered:** 18 April 2014
Categories of care: RC-DE, RC-I	**Number of registered places:** 40

3.0 Methods/processes

Prior to inspection 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 four residents, two senior care staff 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.

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 23 June 2016

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.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 22 October 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** Second time	The maintenance of medication administration records must be improved to ensure that: • each administration of an external preparation by care staff is recorded	**Met**
	Action taken as confirmed during the inspection: Following the last medicines management inspection separate records to document the prescribing and administration of external preparations were implemented. It was found that some administration had not been recorded. The registered manager provided assurances that these medicines had been administered by the staff. She advised of the new process which would be implemented which included training, storage location of these records and the auditing arrangements for these medicines. Details of the planned improvements were forwarded to RQIA immediately after the inspection. Due to the assurances provided by the registered manager, this requirement has not been stated for a third time.	

Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must investigate the observations made in bendroflumethiazide and Pulmicort; a written report of the findings and action taken must be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: A written report of the medicines investigation was received by RQIA.	
Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must put robust arrangements in place for the management of thickening agents to ensure that a care plan is in place and records of the prescribing and administration are maintained.	**Met**
	Action taken as confirmed during the inspection: A care plan and a record of prescribing was maintained. There was evidence that some of the administration had been recorded in the past, but there were no recent records of administration. A sample template to record administration was observed and the registered manager advised that this would be implemented with immediate effect. Due to the assurances provided by the registered manager, this requirement has not been stated for a second time.	
Requirement 4 **Ref:** Regulation 19(2) **Stated:** First time	The registered manager must ensure that where care staff are responsible for the administration of thickening agents and external preparations, records of training and competency are maintained.	**Met**
	Action taken as confirmed during the inspection: There was evidence that care staff had received training and had been deemed competent in delegated medicines tasks.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 31 **Stated:** Second time	The audit process should be expanded to monitor the following: • administration records which are completed by care staff.	**Met**
	Action taken as confirmed during the inspection: Following the last medicines management inspection the registered manager had implemented a system whereby senior care staff were responsible for the auditing of administration records. As some discrepancies were observed, this was discussed with the registered manager who advised that the auditing process would be reviewed, and a daily audit would be implemented with immediate effect. Due to the assurances provided by the registered manager, this recommendation has not been stated for a third time.	
Recommendation 2 **Ref**: Standard 30 **Stated:** First time	The registered manager should further develop the medicine management policies and procedures to ensure these reflect the current practices in Joymount House and include standard operating procedures for controlled drugs.	**Met**
	Action taken as confirmed during the inspection: Written policies and procedures for the management of medicines had been updated; the most recent review was in April 2016.	
Recommendation 3 **Ref**: Standard 31 **Stated:** First time	The registered manager should closely monitor the completion of personal medication records to ensure these are up to date at all times.	**Met**
	Action taken as confirmed during the inspection: An improvement in the standard of maintenance of personal medication records was evidenced at the inspection. These were reviewed within the audit process.	

Recommendation 4 **Ref**: Standard 31 **Stated:** First time	The registered manager should ensure that all handwritten entries on medication administration records involve two members of trained staff and both staff should initial the entry.	**Met**
	Action taken as confirmed during the inspection: The need to record handwritten entries on medication administration records (MARs) occurs regularly, as a number of residents are in receipt of intermediate care or respite care. Two staff were involved in some but not all of the transcribing. Whilst it is the expected practice of the staff, it was ascertained that on several occasions, residents were admitted at times when only one senior care staff was on duty. It was agreed that designated care assistants would be trained up to witness any further transcribing and both staff would initial the MARs. Due to the assurances provided by the registered manager, this recommendation has not been stated for a second time.	
Recommendation 5 **Ref**: Standard 30,31 **Stated:** First time	The management of medicines for distressed reactions should be reviewed to ensure that a care plan is developed and the reason for the administration and the effect of the administration is recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: A care plan was maintained and included the reason for and outcome of the administration.	

4.3 Is care safe?

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. Refresher training was provided in the last year. Update training in relation to diabetes awareness/management and dysphagia is planned for the near future.

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 satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and some handwritten entries on medication administration records were updated by two members of staff. The registered manager advised that a new system would be implemented to ensure that all handwritten entries are checked by two staff with immediate effect.

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. Additional checks were also performed on other controlled drugs which is good practice.

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 recorded. 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 and provided examples. A care plan was not maintained. 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. Details of the prescribed fluid consistency were not stated. There were no records of any recent administration. Following the inspection, the registered manager provided written details of the action to be taken to address this issue and confirmed that the prescribed consistency level had been added to the personal medication records after the inspection. 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 by the staff and management. These focused on medicines which were not supplied in the 28 day blister packs and included nutritional supplements. 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

The management of pain should be reviewed to ensure that where a resident is prescribed medicines to manage pain, this is referenced in a care plan. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

Appropriate arrangements were in place to facilitate residents responsible for the self-administration of medicines.

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 responded in a timely manner to any requests for medicines e.g. pain relief. They spoke positively about the staff and comments included:

- 'They are very good here'.
- 'Am looked after well'.

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 had been updated in April 2016. 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.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence that these had been reported to the registered manager. The registered manager advised of the procedures in place to ensure that the appropriate action was taken and how the learning would be shared with staff. As part of best practice it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

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.

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

Any issues identified during this inspection are detailed in the 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 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 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 *pharmacists@rqia.org.uk* 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 6 **Stated:** First time **To be completed by:** 25 September 2016	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.
	Response by registered provider detailing the actions taken: Pain management will be added to each care plan.

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

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