The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report
2 May 2017

Westlands

Type of service: Residential Care Home
Address: 2 Westland Road, Cookstown, BT80 8BX
Tel No: 028 8672 3922
Inspector: Rachel Lloyd

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Westlands took place on 2 May 2017 from 10.50 to 13.40.

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. 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. Two areas for improvement were identified in relation to record keeping. 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 consulted with confirmed that they were administered their medicines appropriately. 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. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. 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	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Olga Gourley, Senior Care Assistant, as part of the inspection process, since the registered manager was taking a resident to an appointment at the time of feedback. 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 dated 1 December 2016.

2.0 Service details

Registered organisation/registered person: Northern HSC Trust Mr Anthony Baxter Stevens	**Registered manager:** Mr Sean McCartan
Person in charge of the home at the time of inspection: Mr Sean McCartan	**Date manager registered:** 1 April 2005
Categories of care: RC-I	**Number of registered places:** 29

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 - it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

We met with one resident, one senior care assistant 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 1 December 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and was 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 14 May 2015

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** Second time	The registered manager must ensure that medicines are administered only to the resident for whom they were prescribed. **Action taken as confirmed during the inspection**: This was evidenced during the inspection. All medicines were individually labelled and marked with the date of opening. This facilitated a clear audit trail.	**Met**
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 30 **Stated:** Second time	The registered manager should be able to demonstrate the assessment of competency of staff in all aspects of medicines management undertaken in the home. **Action taken as confirmed during the inspection**: Records of competency assessment for the last two years were provided for staff on duty responsible for the management of medicines. The registered manager advised that this was completed annually for all relevant staff.	**Met**
Recommendation 2 **Ref:** Standard 31 **Stated:** Second time	The registered manager should ensure that two members of staff sign the warfarin administration record and check the stock balance to ensure the accuracy of this record. **Action taken as confirmed during the inspection**: No residents were prescribed warfarin. However, evidence that this recommendation had been met was observed in recent medication records and during discussion with staff.	**Met**

Recommendation 3 **Ref:** Standard 30 **Stated:** First time	It is recommended that regular audit of all areas of the management of medicines is undertaken and that records are maintained.	**Met**
	Action taken as confirmed during the inspection: Records of weekly audits including stock balances, records and storage were observed.	
Recommendation 4 **Ref:** Standard 30 **Stated:** First time	It is recommended that a care plan for the use of prescribed medication for administration 'when required' in the management of distressed reactions is in place and is evaluated regularly.	**Met**
	Action taken as confirmed during the inspection: A care plan was in place for the sample of records selected for examination. Staff confirmed this was in place for all relevant residents and that regular evaluation takes place.	

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 annually.

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. A recommendation regarding record keeping was made in section 4.4.

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. 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.

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 largely well maintained and facilitated the audit process. It was observed that administration times on medicines administration records did not match those on personal administration records and were expressed as 'morning' or 'night' rather than a specific time. These should match and be expressed as the time that medicine administration has taken place. A recommendation was made. Personal medication records were usually updated by two members of staff. However, new entries on personal medication records and handwritten entries on printed medication administration records were not checked for accuracy and signed by two competent members of staff. A recommendation was made.

Practices for the management of medicines were audited throughout the month. In addition, a regular audit was completed by the community pharmacist. It was suggested that staff should record the balance carried forward for medicines not supplied in the monitored dosage system, to facilitate audit.

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

Medicine administration times on personal medication records and printed medicine administration records should match and be expressed as the time that medicine administration has taken place. A recommendation was made.

New entries on personal medication records and handwritten entries on printed medication administration records should be checked for accuracy and signed by two competent members of staff. 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. Good relationships were observed between staff and residents.

The resident 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.

As part of the inspection process, questionnaires were issued to residents, relatives/residents' representatives and staff. No responses were received within the specified timescale.

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.

There were arrangements in place for the management of any medicine related incidents. Staff confirmed that they knew how to identify and report incidents.

A review of audit records indicated that good 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 senior care assistant, 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.

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 Olga Gourley, Senior Care Assistant, 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 the 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

<table>
<tr><td colspan="2">Recommendations</td></tr>
<tr><td rowspan="2">Recommendation 1

Ref: Standard 31

Stated: First time

To be completed by:
2 June 2017</td><td>The registered provider should ensure that medicine administration times on personal medication records and printed medicine administration records match and be expressed as the time that medicine administration has taken place.</td></tr>
<tr><td>Response by registered provider detailing the actions taken:
Discussed with pharmacist and now in place</td></tr>
<tr><td rowspan="2">Recommendation 2

Ref: Standard 31

Stated: First time

To be completed by:
2 June 2017</td><td>The registered provider should ensure that new entries on personal medication records and handwritten entries on printed medication administration records are checked for accuracy and signed by two competent members of staff.</td></tr>
<tr><td>Response by registered provider detailing the actions taken:
Discussed with senior care team and now in place</td></tr>
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Please ensure this document is completed in full and returned via web portal

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