The Regulation and

Unannounced Medicines Management Inspection Report
24 June 2016

The Roddens

Type of Service: Residential Care Home
Address: 22 Queen Street, Newal Road, Ballymoney, BT53 6JB
Tel No: 028 2766 3520 or 028 9442 6273
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of The Roddens took place on 24 June 2016 from 10.05 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.

The outcome of the inspection found no areas of concern. A Quality Improvement Plan (QIP) has not been included in this report.

Is care safe?

There was evidence that the management of medicines supported the delivery of safe care. Staff were trained and competent and there were robust processes for the stock control of medicines, management of medicine changes and management of high risk medicines. These processes promoted the delivery of positive outcomes for residents. No requirements or recommendations have been made.

Is care effective?

There was evidence that the management of medicines supported the delivery of effective care. There were processes in place to ensure that the residents were administered their medicines as prescribed and robust arrangements were in place for the management of anticoagulants. No requirements or recommendations have been made.

Is care compassionate?

There was evidence that the management of medicines supported the delivery of compassionate care. Staff interactions with residents were observed to be compassionate, caring and timely. Residents spoke positively of their care in the home and the management of their medicines. No requirements or recommendations have been made.

Is the service well led?

There was evidence that the service was well led with respect to the management of medicines. Written medicine policies and procedures were in place. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. These promoted the delivery of positive outcomes for residents. No requirements or recommendations have been 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**	**0**

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mr Philip Dawson, 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 18 April 2016.

2.0 Service details

Registered organisation/ registered provider: Northern HSC Trust/ Dr Anthony Baxter Stevens	**Registered manager:** Not applicable
Person in charge of the home at the time of inspection: Mr Philip Dawson (new manager since 1 June 2016)	**Date manager registered:** Mr Philip Dawson – application not yet submitted
Categories of care: RC-I	**Number of registered places:** 29

3.0 Methods/processes

Prior to 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

We met with the manager, two residents and one member of senior care staff.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector. No one availed of the opportunity.

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 18 April 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 their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 8 October 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The manager must ensure that written care plans are in place for the two residents identified at the inspection. **Action taken as confirmed during the inspection**: This had been addressed and was confirmed by the registered manager, following the last medicines management inspection.	**Met**
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The manager must report the observations made in Seretide Accuhalers to the prescribers. **Action taken as confirmed during the inspection**: This had been addressed and was confirmed by the registered manager, following the last medicines management inspection. This medicine was not prescribed for any residents currently accommodated in the home.	**Met**

<table>
<tr><td rowspan="2">Requirement 3

Ref: Regulation 13(4)

Stated: First time</td><td>The manager must ensure that written confirmation of medicine regimes is received for each resident admitted for a period of respite care.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was evidence that written details of residents' medicine regimes were received at or prior to admission to the home.</td></tr>
<tr><td rowspan="2">Requirement 4

Ref: Regulation 13(4)

Stated: First time</td><td>The manager must update the care plans for residents with regard to hypoglycaemia, self-administered medicines and swallowing difficulty.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The completed QIP stated that these care plans had been updated following the last medicines management inspection. At the time of this inspection, insulin and thickening agents were not prescribed. A care plan was maintained for a resident who was responsible for the self-administration of medicines.</td></tr>
<tr><td rowspan="2">Requirement 5

Ref: Regulation 13(4)

Stated: First time</td><td>The manager must closely monitor the management of inhaled medicines to ensure these are being administered as prescribed.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There were arrangements in place to ensure that inhalers were administered as prescribed. There were no further concerns regarding the administration of inhaled medicines.</td></tr>
<tr><td rowspan="2">Requirement 6

Ref: Regulation 13(4)

Stated: First time</td><td>The manager must ensure that all incoming medicines are clearly labelled and each medicine is identifiable.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
All of the medicines examined at the inspection were clearly labelled and those supplied in 7 day packs could be readily identified.</td></tr>
</table>

Requirement 7 **Ref**: Regulation 13(4) **Stated:** First time	The manager must ensure that records of the administration of external preparations are fully and accurately maintained on every occasion. **Action taken as confirmed during the inspection**: This area of medicines management had been reviewed. All external preparations were administered by senior care staff and records maintained. There were no further concerns regarding the administration of external preparations.	**Met**
Requirement 8 **Ref**: Regulation 13(4) **Stated:** First time	The manager must ensure that the refrigerator thermometer is reset every day. **Action taken as confirmed during the inspection**: The refrigerator thermometer was reset each day; this activity was completed by staff on night duty.	**Met**
Requirement 9 **Ref**: Regulation 13(4) **Stated:** First time	The manager must review the management of thickened fluids to ensure that the relevant records are being maintained. **Action taken as confirmed during the inspection**: Thickened fluids were not prescribed for any residents currently accommodated in the home. The manager advised of the procedures in place, and the records that had been implemented and developed following the last medicines management inspection.	**Met**
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	The manager should review the audit process to ensure that all aspects of medicines management are included. **Action taken as confirmed during the inspection**: The audit process had been reviewed. New procedures had been implemented to ensure that all medicines were marked with the date of opening and a specific list of medicine related areas was reviewed at supervision, competency assessment and appraisal.	**Met**

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 and had been completed this month for a number of staff.

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 were updated by two members of staff. This safe practice was acknowledged.

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. The manager advised of the arrangements in place for residents who were in receipt of intermediate care and the procedures to ensure the ease of transition with regard to residents managing their medicines following 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. anticoagulant medicines. The good practice of maintaining a separate administration chart and running stock balance for the new anticoagulant medicines 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 and three monthly 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. These medicines were not often required; the reason for and outcome of the administration were usually recorded. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour. A care plan was maintained and it was agreed that this would be developed to include further detail on the management of distressed reactions.

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 pain and could request intermittent pain relief. A care plan was maintained. The management of distressed reactions and the consideration of pain was discussed in relation to residents who may not be able to communicate pain. The manager advised that this was an area that was to be reviewed later this month.

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. Areas of good practice were acknowledged. They included the maintenance of separate receipt records per resident and the maintenance of a permanent record of the date of opening for most medicines. Staff were reminded that the date of transfer of medicines to the community pharmacy should be recorded on every occasion.

Practices for the management of medicines were audited throughout the month by the staff and management. In addition, a quarterly audit was completed by the community pharmacist. It was suggested that the medicine audit records should also include the audits which had been performed on other medicines formulations e.g. nutritional supplements, eye preparations.

Following discussion with the manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to issues or concerns pertaining 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?

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

The administration of medicines to residents was observed during the inspection. The staff administered the medicines in a caring manner and residents were given time to take their medicines.

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:

"I like it here."
"I am happy here."
"I don't mind how long I stay here."

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. 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. There was evidence of the action and learning implemented following incidents. Staff provided an example of where an incident had resulted in a change of practice and a review of procedures to ensure that the staff were not disturbed during medicine rounds.

A review of the internal audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the manager and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff advised that management were open and approachable and willing to listen. They spoke positively about their work and stated that there were good working relationships within the home.

The requirements and recommendations made at the last medicines management inspection had been addressed, indicating a robust response to regulation.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated individually with staff and at team meetings.

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.

5.0 Quality improvement plan

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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