Unannounced Medicines Management Inspection Report
23 February 2018

Rosedale

Type of service: Residential Care Home
Address: 100 Kilgreel Road, Antrim, BT41 1EH
Tel No: 028 9442 9402
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 which is registered to provide care for up to 38 persons over the age of 65 years who require residential care.

The home has a small number of permanent residents; the majority of places in the home are occupied by short term admissions for a period of recovery before discharge either home or on to permanent care placements.

3.0 Service details

Organisation/Registered Provider: Northern HSC Trust **Responsible Individual:** Dr Anthony Baxter Stevens	**Registered Manager:** Mrs Heather Susan Allison
Person in charge at the time of inspection: Mrs Roberta Preston (Senior Care Assistant)	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) I – Old age not falling within any other category	**Number of registered places:** 38 The home is also approved to provide care on a day basis only to four persons.

4.0 Inspection summary

An unannounced inspection took place on 23 February 2018 from 10.10 to 13.40.

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 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 medicines administration, the completion of most medicine records, medicines storage and the management of controlled drugs.

Areas requiring improvement were identified in relation to antibiotics, distressed reactions and external preparations.

Residents spoke positively about the management of their medicines and their care in the home. They were relaxed and comfortable in their surroundings and interactions with 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	3

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Roberta Preston, Senior Care Assistant, 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

The most recent inspection of the home was an unannounced care inspection undertaken on 21 September 2017. Other than those actions detailed in the QIP no further actions were required to be taken. 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 incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

A poster was displayed to inform visitors to the home that an inspection was being conducted.

During the inspection the inspector met with two residents, two care assistants, the administrator and the person in charge of the home.

Ten questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

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

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 21 September 2017

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 18 November 2014

There were no areas for improvement identified as a result of the last medicines management inspection.

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. A sample of training records was observed. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management, dementia and diabetes awareness was provided in the last year. Staff also confirmed that they had received training in the management of oxygen.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training was completed 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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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. Staff confirmed that all medicines were explained to residents and their families at the time of discharge from the home.

The management of medicine changes was reviewed. Largely satisfactory systems were in place. Medicines changes were recorded in the residents' care files and also on their personal

medication records. The writing/rewriting of personal medication records involved two staff, which is safe practice. Staff were reminded that any updates should also be signed by two staff. It was agreed that this would be commenced from the day of the inspection onwards.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. The controlled drug record book was not sequentially numbered; this was discussed and staff advised that it would be addressed at the earliest opportunity. 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 and insulin. Care plans were maintained.

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 very 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 and oxygen equipment were checked at regular intervals.

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Of the audit trails completed on a variety of medicines, the majority of outcomes indicated that medicines had been administered in accordance with the prescriber's instructions. However, discrepancies were noted in three antibiotic medicines. An area for improvement was identified. It was suggested that a running stock balance should be maintained for these medicines.

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. 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 the administration was occasionally recorded. This should be recorded on each occasion and include details of the outcome of the administration. 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. Staff advised that the residents could express pain and they confirmed that they were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. A care plan was maintained.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record and the details of the fluid consistency were added during the inspection. Each 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 the maintenance of a permanent record of the date of opening of medicines. However, it was noted that records of the administration of external preparations were incomplete. This was discussed with staff and we were informed that these medicines were being administered; however, the staff had not signed the record. An area for improvement was identified.

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.

Following discussion with the staff and a review of care files, it was evident that when applicable, other healthcare professionals are contacted in response to residents' healthcare needs.

Areas of good practice

There were some examples of good practice in relation to the standard of record keeping, care planning and the administration of most medicines. Staff were knowledgeable regarding the residents' medicines.

Areas for improvement

The administration of antibiotics should be closely monitored to ensure that these are administered as prescribed.

The management of distressed reactions should be reviewed to ensure that the reason for and outcome of administration of medicines are fully recorded on each occasion.

The administration of external preparations should be closely monitored to ensure that administration records are fully completed.

	Regulations	Standards
Total number of areas for improvement	0	3

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.

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 the interactions between the staff and the residents' visitors and it was evident from these that there was a good rapport between them.

The residents we met with spoke positively about their care in the home and the management of their medicines. They were complimentary regarding staff. Comments included:

"The girls are excellent, you couldn't get better."
"I am getting on well and I am happy here."
"The food is good; today's lunch was very nice."

Of the questionnaires that were issued to receive feedback from residents and their representatives, six were returned. The responses indicated that they were very satisfied with all aspects of the care in the home. One comment was made:

"Foods good".

Areas of good practice

Staff listened to residents and their representatives 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.

Written policies and procedures for the management of medicines were in place. These had been recently updated and there was evidence that staff had read them in January 2018.

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

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and review by management. It was suggested that the audit process should be further developed as per inspection findings and it was agreed that this would be raised with the registered manager.

Following discussion with the staff, it was evident that they 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. They advised that any resultant action was communicated with them through team meetings and supervision. They advised that there were good relationships in the home and with management.

The staff we met with spoke positively about their work. Comments included:

“I love my work and have worked here for many years.”
“We all work well together.”

There were no online questionnaires completed by staff within the specified timescale (two weeks).

Areas of good practice

There were examples of good practice in relation to governance arrangements and the management of medicine incidents. 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 Mrs Roberta Preston, Senior Care Assistant, 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 the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 25 March 2018	The registered person shall develop a monitoring process for antibiotic medicines to ensure that these are administered as prescribed. Ref: 6.5
	Response by registered person detailing the actions taken: A separate Audit Sheet will be completd for the monitoring process of Administration of Antibiotics with immediate effect.
Area for improvement 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 25 March 2018	The registered person shall review the management of distressed reactions to ensure that details of the reason for and outcome of any administration are recorded on each occasion. Ref: 6.5
	Response by registered person detailing the actions taken: Senior staff re-educated as to this requirement and will be included in Managers' Audits with immediate effect.
Area for improvement 3 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 25 March 2018	The registered person shall ensure that medicines administration records in relation to external preparations are fully maintained. Ref: 6.5
	Response by registered person detailing the actions taken: All external preparations will be included in Medicine Kardex and signed for as per instructions with immediate effect.

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

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