Unannounced Medicines Management Inspection Report
9 August 2016

Castle Lodge Care Home

Type of service: Residential Care Home
Address: 7-9 Fennel Road, Antrim, BT41 4PB
Tel No: 028 9442 8212
Inspector: Frances Gault

1.0 Summary

An unannounced inspection of Castle Lodge Care Home took place on 9 August 2016 from 09:30 to 12:50.

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 patients. 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. There were no areas of improvement identified.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. One area of improvement was identified in relation to liquid medicines and a recommendation was 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 patients. Residents consulted with confirmed that they were administered their medicines appropriately. There were no areas of 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 of 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	1

Details of the QIP within this report were discussed with Mrs Una Brady, 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 25 May 2016.

2.0 Service details

Registered organisation/ registered provider: Four Seasons (Bamford) Ltd Dr. Maureen Claire Royston	**Registered manager:** Mrs Una Brady
Person in charge of the home at the time of inspection: Mrs Una Brady	**Date manager registered:** 5 August 2010
Categories of care: RC-DE, RC-I	**Number of registered places:** 39

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- the management of medicine related incidents reported to RQIA since the last medicines management inspection

We met with three residents, two care staff, the deputy manager and 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.

The following records were examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- 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 25 May 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 26 August 2014

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 32 **Stated:** First time	The registered manager should ensure that all quantities of Schedule 3 controlled drugs subject to safe custody requirements are reconciled on each occasion when responsibility for safe custody is transferred.	**Met**
	Action taken as confirmed during the inspection: The evidence seen during this inspection indicated that this is now the practice.	

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. Recent training included information from the community nurses on stoma care, and 'in house' training and competency assessments for care staff on the administration of external preparations.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration 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. One resident may visit the general practitioner independently and obtain supplies of additional medication. The possible risks involved were discussed and it was suggested that these should be identified in a care plan.

No controlled drugs subject to record keeping requirements were currently prescribed in the home. Checks were performed on those 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 warfarin. The use of separate administration charts was acknowledged.

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 and oxygen equipment 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 majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. There were significant discrepancies in two of the liquid medicines audited and it was noted that, in both instances, more than one supply had been in use. It was recommended that liquid medicines should be closely monitored in order to ensure that they are administered as prescribed.

There was evidence that time critical medicines had been administered at the correct time. Arrangements were in place to alert staff of when doses of weekly, monthly or three monthly medicines were due. District nursing services regularly visit the home to attend to the health needs of residents.

When residents were prescribed medicines for administration on a 'when required' basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. Additional sheets are on the medicine file indicating when the medicine is to be administered and the outcome of each administration. 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 could be associated with pain. 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.

The behavioural team had given the staff advice in relation to a resident with dementia where pain could be causing distress. This had been detailed in the care plan.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. 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.

Medicine records were usually well maintained and facilitated the audit process. Attention was drawn to a few instances where recently prescribed medicines had not been included on the personal medication record and the registered manager agreed that these would be addressed.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines. The outcomes of medicine audits were discussed at staff meetings.

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

Areas for improvement

The audit process should be reviewed to ensure liquid preparations are closely monitored in order to confirm that they are administered as prescribed.

Number of requirements:	**0**	**Number of recommendations**:	**1**

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. Residents were seen approaching staff when they required pain relief or ear drops. Residents were guided to their bedrooms to ensure that their privacy was maintained for the administration of ear drops.

Residents spoken with were all positive about their care. Bingo was being played during the inspection and one resident was delighted by her win and small prize.

One resident explained that she was currently on ear drops but hoped that her visit the next day to the surgery would find the problem resolved.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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 and readily available on the medicine trolley. 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. Trends had been identified and the registered manager was able to demonstrate the action taken and learning implemented following these.

The manager advised that the internal audits were analysed. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice. Discussion took place regarding the auditing of liquid medicines (see section 4.4).

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.

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 Mrs Una Brady, 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 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 30 **Stated:** First time **To be completed by:** 30 September 2016	The registered provider should closely monitor the administration of liquid medicines to ensure that these are administered as prescribed.
	Response by registered provider detailing the actions taken: Weekly audits of bottled medicines is in place. This also will be monitored by the Manager/ Deputy Manager.

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

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