Unannounced Medicines Management Inspection Report
25 July 2018

Rosemary Lodge Care Home

Type of service: Residential Care Home
Address: 9 Fennel Road, Antrim, BT41 4PB
Tel No: 028 9442 8877
Inspector: Paul Nixon

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 with 44 beds that provides care for residents with a variety of care needs, as detailed in section 3.0.

3.0 Service details

Registered organisation/registered person: Four Seasons (Bamford) Ltd/ Dr Maureen Claire Royston	**Registered manager:** See below
Person in charge of the home at the time of inspection: Mrs Una Brady (Support Manager from same organisation)	**Date manager registered:** Ms Joanne Hull Registration pending, awaiting application
Categories of care: Residential Care (RC): I - Old age not falling within any other category DE – Dementia MP (E) - Mental disorder excluding learning disability or dementia – over 65 years LD - Learning Disability PH (E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 44 including not more than two residents in category RC-LD

4.0 Inspection summary

An unannounced inspection took place on 25 July 2018 from 09.00 to 14.10.

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 during and 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, medicine records and medicine storage.

An area for improvement was identified in relation to controlled drug records.

There was a warm and welcoming atmosphere in the home. Residents were relaxed and good relationships with staff were evident. They spoke positively about the management of their medicines and the care provided in the home. They were complimentary about the staff and management.

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	1	0

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Una Brady, Support Manager from the same organisation, 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

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection on 18 July 2018. 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 service was reviewed. This included the following:

- 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.

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

During the inspection we met with four residents, one resident's representative, a support manager from the same organisation and four members of care staff.

Ten questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. At the request of the inspector, the person-in-charge was asked to display a poster in the home which invited staff to share their views of the home by completing an online questionnaire.

The inspector left "Have we missed you?" cards. The cards facilitate residents or relatives who were not present at the time of the inspection to give feedback to RQIA on the quality of service provision. Flyers which gave information on raising a concern were also left in the home.

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
- care plans
- training records
- medicines storage temperatures

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

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 18 July 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be reviewed 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 1 December 2016

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 6	The registered provider should review the care plans for residents with diabetes to ensure, where appropriate, that they contain details of the identification and action taken in the event of a hypoglycaemic episode.	**Met**
	Action taken as confirmed during the inspection: There were no insulin dependent diabetics; however, staff confirmed that care plans had been updated to include details of the identification and action in the event of a hypoglycaemic episode.	
Area for improvement 2 **Ref**: Standard 32	The registered provider should review the storage of medicines within the medicine trolleys.	**Met**
	Action taken as confirmed during the inspection: Medicines were being appropriately stored in the three medicine trolleys.	

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. 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 in medicines management was provided on 19 June 2018.

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 had been received into the home without delay.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. Handwritten entries on medicine administration records were normally updated by two members of staff. This safe practice was acknowledged.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

There were procedures in place to ensure the safe management of medicines during a resident's admission to 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. However, several recent administrations and one recent receipt had not been recorded in the controlled drug record book; an area for improvement was identified. 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. The medicine storage capacity had recently been reviewed by management and a decision had been made to install additional storage cupboards. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The medicine refrigerator was checked at regular intervals.

Areas of good practice

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

Areas for improvement

The controlled drugs record book must be fully and accurately maintained.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

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

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 medicines prescribed to be administered at atypical intervals 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. However, for the two residents whose records were examined, a care plan was not maintained. At the commencement of the inspection the support manager from the same organisation stated that this matter had recently been identified and it was currently being rectified. These medicines were seldom used.

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. For the two residents whose records were examined, a care plan was maintained.

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 mostly well maintained and facilitated the audit process.

Practices for the management of medicines were audited throughout the month by the management and staff. Because of an increase in the number of medicine incidents, audits were being performed on a daily basis. The audits included running stock balances for almost all of the solid dosage medicines. In addition, a periodic audit was completed by the community pharmacist.

Following discussion with the staff, it was evident that other healthcare professionals are contacted, when required, to meet the needs of residents. Staff advised that they had good working relationships with healthcare professionals involved in the residents' care.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were noted to be friendly and courteous. They treated the residents with dignity.

The residents we spoke with advised that they were satisfied with the management of their medicines and the care provided in the home. They were complimentary regarding staff and management. Comments made included:

- “I am looked after very well; I have no complaints.”
- “The care is good; staff are very good; the food is very good; I get my medicines from the staff.”
- “Care is very good; the staff are all very nice.”
- “I am cared for very well; I get my medicines from the staff.”

One relative spoken to stated they were satisfied with the care provided.

None of the questionnaires that were left for residents and relatives to complete were returned.

Areas of good practice

Staff listened to residents and relatives 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.

We discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents. Arrangements are place to implement the collection of equality data within Rosemary Lodge Care Home.

Written policies and procedures for the management of medicines were in place. These were not examined in detail. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them. It was evident that they were familiar with their roles and responsibilities in relation to medicines management.

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. Any anomalies in the medicine administration procedures identified by the robust internal auditing system were reported to RQIA as incidents. There was evidence of the action taken and learning implemented following 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 learning which had resulted in a change of practice.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that management were open and approachable and willing to listen.

No members of staff shared their views by completing an online questionnaire

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. 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 QIP. Details of the QIP were discussed with Mrs Una Brady, Support Manager from the same organisation, 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 via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 24 August 2018	The registered person shall ensure that the controlled drugs record book is fully and accurately maintained. Ref: 6.4
	Response by registered person detailing the actions taken: The controlled drugs record will be checked by the Registered Person during the completion of Home Manager's Monthly Medication Audit to ensure it is fully and accurately maintained.

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

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