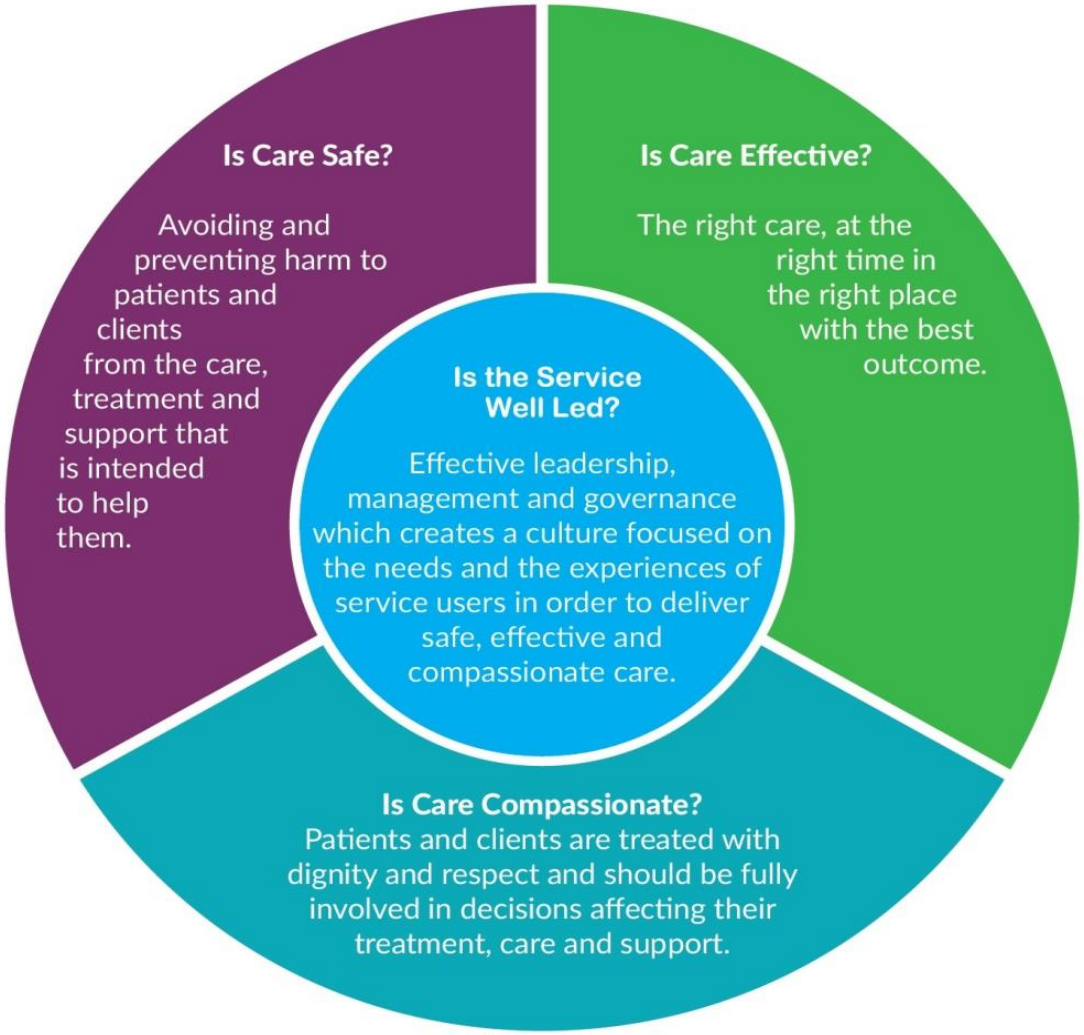
Unannounced Medicines Management Inspection Report
2 May 2018

Fairlawns

Type of service: Residential Care Home
Address: 63 Drumcairn Road, Armagh, BT61 8DQ
Tel No: 028 3752 5074
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 56 beds that provides care for residents with a variety of care needs, as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Fairlawns **Responsible Individual:** Mr Michael Murphy	**Registered Manager:** Mrs Claire Patricia Cassidy
Person in charge at the time of inspection: Ms Ruth Brimage (Deputy Manager)	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) I – Old age not falling within any other category DE – Dementia MP – Mental disorder excluding learning disability or dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH – Physical disability other than sensory impairment	**Number of registered places:** 56 including: A maximum of 11 residents in category of care RC-I. Three named individuals accommodated in Fairlawns House under category of care RC-I. All other category RC-I residents to be accommodated in Fairlawns Lodge. A maximum of two residents in category RC-MP. A maximum of four residents in category RC-PH. The home is approved to provide care on a day basis only to five persons.

4.0 Inspection summary

An unannounced inspection took place on 2 May 2018 from 09.45 to 14.05.

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 storage and the management of controlled drugs.

Areas for improvement were identified in relation to care planning and medicine 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	*1

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Ms Ruth Brimage, Deputy 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.

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 20 February 2018. 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 medicine related incidents reported to RQIA since the last medicines management inspection.

During the inspection the inspector met with four residents, the deputy manager and five members of care staff.

A total of 10 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 poster informing visitors to the home that an inspection was being conducted was displayed.

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 20 February 2018

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 27 September 2016

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered provider must ensure that robust arrangements are in place for the safe management of medicines during admission.	**Met**
	Action taken as confirmed during the inspection: For planned admissions, where a resident comes from their home address, a current list of prescribed medication is requested from the resident's GP. Whenever, a resident is transferred from hospital, staff obtain a copy of the hospital discharge summary with current medication list signed by hospital doctor.	

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 31 **Stated:** First time	The registered provider should ensure a copy of current prescriptions is retained in the home.	**Met**
	Action taken as confirmed during the inspection: Copies of current prescriptions were retained on file.	
Area for improvement 2 **Ref**: Standard 31 **Stated:** First time	The registered provider should ensure personal medication records are verified and signed by two designated members of staff.	**Met**
	Action taken as confirmed during the inspection: Personal medication records were verified and signed by two designated members of staff. However, one new area for improvement was identified in relation to the maintenance of personal medication records (see Section 6.5)	
Area for improvement 3 **Ref**: Standard 6 **Stated:** First time	The registered provider should ensure that where a resident is prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the management of the medicine is detailed in a care plan and the reason for and outcome of administration is recorded on each occasion.	**Partially met**
	Action taken as confirmed during the inspection: For two of the three residents whose records were examined, the management of the medicine was not detailed in their care plan. These medicines were infrequently used; however, staff described the arrangements for recording the reason for and outcome of their administration in the residents' progress notes. **This area for improvement was stated for a second time.**	

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 at the end of the induction process and reviewed annually. Refresher training in medicines management was provided since the last medicines management inspection, following a change in the monitored dosage system supplied by the community pharmacy.

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.

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. 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.

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 of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

The sample of medicines examined had generally been administered in accordance with the prescriber's instructions. One audit discrepancy was drawn to the attention of the deputy manager.

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, monthly or three monthly medicines were due.

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 the residents could verbalise any pain. A care plan was maintained. Staff also advised that a pain assessment is completed as part of the admission process.

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.

With the exception of personal medication records, the medicine records were maintained in a satisfactory manner and facilitated the audit process. Eight residents did not have a personal medication record. Some personal medication records had been inaccurately maintained, with recently prescribed medicines or antibiotic courses not added, recently discontinued medicine entries not cancelled or the wrong dose specified. Also, some residents did not have their medicine allergy status declared on their personal medication record. These observations indicated that the personal medication records were not being used as an integral part of the medicines administration process, with staff primarily referring to the medicine administration record sheets. This is necessary for the safe and effective administration of medicines both within the home and if the resident needs to be admitted to hospital. An area for improvement was identified.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some solid dosage medicines and inhaled medicines. In addition, a periodic audit was completed by the community pharmacist. The need for the maintenance of the personal medication records to be closely monitored was discussed with the deputy manager, who gave an assurance that this would be implemented.

Following discussion with the deputy manager and 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 care planning and the administration of medicines.

Areas for improvement

Each resident must have a personal medication record that is accurately maintained and used as an integral part of the medicines administration process.

	Regulations	Standards
Total number of areas for improvement	1	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.

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were noted to be friendly, courteous and happy in their work; 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:

"Care is okay; staff are good; I get my medicines; I have no issues."
"It's nice enough here; care is good; staff are all nice; food is good."
"It's pretty good here; staff are good; food is very good; I get my medicines."
"It's good here; staff are very good; food is okay; I get my medicines; I have no issues."

Of the questionnaires that were issued, five were returned from residents or from relatives. The responses indicated that they were very satisfied/satisfied with the care provided.

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.

The inspector 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 were place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. Following discussion with staff it was evident that they were knowledgeable with the policies and procedures and that any updates were highlighted to them.

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 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.

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

Not all of the areas for improvement from the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement sustained, it was strongly suggested that the QIP should be regularly reviewed as part of the quality improvement process.

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 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 Ms Ruth Brimage, Deputy Manager, 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 with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 1 June 2018	The registered person shall ensure that each resident has a personal medication record that is accurately maintained and used as an integral part of the medicines administration process. Ref: 6.5
	Response by registered person detailing the actions taken: Manager reviewed individual medication records. Personal medication records now in place. Supervision was undertake with staff regarding required record keeping, maintainence of up to date records and use of same. Compliance with record requirement is audited on a weekly basis.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 6 **Stated:** Second time **To be completed by:** 1 June 2018	The registered provider should ensure that where a resident is prescribed a medicine for administration on a “when required” basis for the management of distressed reactions, the management of the medicine is detailed in a care plan and the reason for and outcome of administration is recorded on each occasion. Ref: 6.2
	Response by registered person detailing the actions taken: Review of individual resident records undertaken. Residents prescibed "when required" medication for management of distressed reactions have care plans in place. Evaluation records are placed along with medication record sheets to record administration of "when required" medication, (in management of destressed reactions) , and effect of same. Auditing of use of same is undertaked regularly by management staff.

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

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