Unannounced Medicines Management Inspection Report
27 September 2016

Fairlawns

Type of service: Residential Care Home
Address: 63 Drumcairn Road, Armagh, BT61 8DQ
Tel No: 028 3752 5074
Inspector: Helen Mulligan

1.0 Summary

An unannounced inspection of Fairlawns took place on 27 September 2016 from 10:00 to 15:45.

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. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. Three areas for improvement in relation to medicine records, the ordering process and the admission process for new residents were identified. One requirement and two recommendations were made.

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 for improvement was identified in relation to the management of distressed reactions. One 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. No areas for improvement were identified.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. No areas for improvement were 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	1	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Claire Cassidy, 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 and estates inspection

There were no further actions required to be taken following the most recent inspection on 28 July 2016.

2.0 Service details

Registered organisation/registered person: Fairlawns/Mr Michael Murphy	**Registered manager:** Mrs Claire Patricia Cassidy
Person in charge of the home at the time of inspection: Mrs Claire Patricia Cassidy	**Date manager registered:** 01 April 2005
Categories of care: RC-I, RC-MP(E), RC-DE, RC-MP, RC-PH	**Number of registered places:** 56

3.0 Methods/processes

Prior to inspection we analysed the following records:

- 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 eight residents, one senior care assistant, the deputy manager and the registered manager.

The following records were 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 28 July 2016

The most recent inspection of the home was an unannounced care and estates inspection. The care and estates inspectors carried out a pre-registration inspection to review an application made by the home to increase the number of registered beds from 45 to 56. No QIP was issued at this inspection and the additional 11 beds have been registered by RQIA.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 23 October 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** Second time	The frequency of audits must be increased and close monitoring is necessary to ensure that inhaled medicines are administered as prescribed.	**Met**
	Action taken as confirmed during the inspection: Records showed that the registered manager has audited records of the administration of medicines on a two-monthly basis. The community pharmacist has also completed a comprehensive audit of medicines management in the home on a quarterly basis. A sample of six prescribed inhalers was audited during the inspection; five of these audits produced satisfactory results, indicating that they had been administered as prescribed. In addition, a running stock balance was maintained for supplies of Spiriva capsules for inhalation. This is good practice. The sixth inhaler audited did not produce a satisfactory result. The registered manager agreed that inhalers would continue to be closely monitored. As a result of the improvements noted in the management of inhalers and the assurances given by the registered manager that inhalers will continue to be monitored and audited as part of the home's monitoring arrangements for medicines, this requirement was assessed as met.	
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** Second time	The specified improvements must be made to the personal medication record and the medicine administration record.	**Met**
	Action taken as confirmed during the inspection: The route of administration was recorded on the personal medication records, the time of administration of bisphosphonate medicines was accurately recorded and medicines prescribed on a "when required" basis were qualified with the maximum daily dose and/or frequency of administration. Records of medicines administered were adequately maintained.	

Requirement 3 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that those medicines which showed poor audit outcomes during the inspection are closely audited and administered in accordance with prescribed instructions.	**Met**
	Action taken as confirmed during the inspection: At the previous medicines inspection, discrepancies were noted in the audits of inhalers, Movicol, Calogen and Co-Careldopa. Improvements were noted in the audits of these medicines during this inspection. Separate records for recording the administration of supplements, including Calogen were in place and this is good practice.	
Requirement 4 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that when issues arise, that the appropriate action is taken to ensure that they do not recur.	**Met**
	Action taken as confirmed during the inspection: Records showed that the outcome of audits carried out by the registered manager and the community pharmacist had been shared with staff at their supervision. Records showed that there had been an improvement in the management and completion of records of medicines administered.	
Requirement 5 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must ensure that the refrigerator temperature is monitored and recorded daily.	**Met**
	Action taken as confirmed during the inspection: The temperature of the medicines refrigerator has been monitored and recorded on a daily basis.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 31 **Stated:** First time	The registered manager should review the layout of the personal medication record.	**Met**
	Action taken as confirmed during the inspection: Updated personal medication records were brought into use following the last medicines management inspection.	

Recommendation 2 **Ref**: Standard 31 **Stated:** First time	The registered manager should ensure that the witness to the administration of controlled drugs, signs the controlled drug record book at the time of the administration.	**Met**
	Action taken as confirmed during the inspection: A sample of records in the controlled drugs record book was audited. Records of the administration of controlled drugs were signed by the person administering them and the person witnessing the administration.	

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. Competency assessments were completed annually. The need to provide update training on the management of diabetes was discussed and the registered manager agreed that this would be addressed at the earliest opportunity.

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. Staff were advised that a copy of current prescriptions should be kept in the home. A recommendation was made. Medicine orders for repeat medicines were not made by staff and staff did not review the prescriptions prior to dispensing. This is best practice and was discussed with reference to the Health and Social Care Board guidance. It was agreed that this would be reviewed.

Personal medication records were not verified and signed by two members of staff. This should be addressed. A recommendation was made.

Robust procedures were not in place to ensure the safe management of medicines during a resident's admission to the home. One recently admitted resident was reviewed; there was no personal medication record for this resident and staff had not verified the resident's current medicines with the prescriber. This must be addressed. A requirement was made.

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 and insulin. The use of separate administration charts was acknowledged. Insulin is administered by the community nursing team. The registered manager was reminded that robust systems should be in place to ensure all insulin pens in use are appropriately labelled and marked with the date of opening.

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 and oxygen equipment were checked at regular intervals. The registered manager was reminded that the temperature of the medicines storage room should not exceed 25°C.

Areas for improvement

A copy of current prescriptions should be kept in the home. A recommendation was made.

Personal medication records should be verified and signed by two members of staff. A recommendation was made.

Robust arrangements must be in place to ensure the safe management of medicines during admission. A requirement was made.

Number of requirements	1	**Number of recommendations**	2

4.4 Is care effective?

A sample of medicines was examined; the majority of these had been administered in accordance with the prescriber's instructions. One discrepancy in the audit of an inhaler was noted (see Section 4.2) and there was a significant discrepancy in one supply of Peptac liquid. These discrepancies were discussed with the registered manager and it was agreed that medicines would continue to be closely monitored using the home's auditing procedures. 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.

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. The reason for and the outcome of administration were not recorded and this should be addressed. A care plan was maintained which made reference to the prescribed medicine but did not detail the parameters for administration. This should be addressed. A recommendation was made.

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, and a pain tool was used as needed. A care plan was not maintained. The registered manager advised this would be addressed. Staff 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.

Medicine records were generally well maintained and facilitated the audit process. Areas of good practice were noted including patch application and removal records and separate insulin, supplements and warfarin records.

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, nutritional supplements and inhaled medicines. In addition, a quarterly audit has been completed by the community pharmacist.

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

Areas for improvement

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 should be detailed in a care plan and the reason for and outcome of administration should be recorded on each occasion that it is administered. A recommendation was made.

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 and residents were given time to take their medicines. Pain relief was offered to residents during the medicine round.

It was noted that staff were not checking the personal medication records during the administration process. The registered manager and staff on duty were reminded that personal medication records should be checked each time a medicine is administered.

Eye drops were administered to one resident in the dining room. This practice was discussed with regard to infection control and privacy and the registered manager agreed the process would be reviewed.

Staff were reminded that flucloxacillin capsules should be administered on an empty stomach.

Residents advised:

"Yes, I got my medicines this morning."
"I'm very happy here."
"I don't have any pain"

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 the majority of medicines were in place. There was no written policy and procedures for the management of anticoagulant medicines (warfarin); the registered manager agreed that this would be addressed. 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 taken and learning implemented following incidents.

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

The requirements and recommendations made at the last medicines management inspection have been addressed.

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 Claire Cassidy, 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 registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be 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

Statutory requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 27 October 2016	The registered provider must ensure that robust arrangements are in place for the safe management of medicines during admission.
	Response by registered provider detailing the actions taken: Staff request current list from residents GP. for planned admissions where resdients are coming from home address. Resdients transferred from hospital - staff obtain copy of hospital discharge summary with current medication list signed by Hospital Doctor.
Recommendations	
Recommendation 1 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 27 October 2016	The registered provider should ensure a copy of current prescriptions is retained in the home.
	Response by registered provider detailing the actions taken: Copies of current prescriptions are made and retained in residents personal medication list.
Recommendation 2 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 27 October 2016	The registered provider should ensure personal medication records are verified and signed by two designated members of staff.
	Response by registered provider detailing the actions taken: A review of psersonal medication records has been undertaken. Two designated members of staff to sign same as recommended
Recommendation 3 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 27 October 2016	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.
	Response by registered provider detailing the actions taken: A review of medications prescribed on a "when required" basis. For the management of distressed reactions has been undertaken. Care plans have ben developed for individuals prescribed same. Staff records the reason for and outcome of administration each time it is administered.

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

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