Unannounced Medicines Management Inspection Report
11 December 2018

Parkanaur College

Type of service: Residential Care Home
Address: 57 Parkanaur Road, Dungannon, BT70 3AA
Tel No: 028 8776 1272
Inspector: Helen Daly

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 that provides care for up to 24 residents with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Thomas Doran Trust **Responsible Individual:** Mr Wilfred Johnston Mitchell	**Registered Manager:** Mr Waldemar Mietlicki
Person in charge at the time of inspection: Mr Waldemar Mietlicki	**Date manager registered:** 2 August 2016
Categories of care: Residential Care (RC): MP – mental disorder excluding learning disability or dementia LD – learning disability LD(E) – learning disability – over 65 years PH – physical disability other than sensory impairment	**Number of registered places:** 24 The home is approved to provide care on a day basis only for one person

4.0 Inspection summary

An unannounced inspection took place on 11 December 2018 from 10.20 to 13.05.

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 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 majority of medicine records and the storage of medicines.

One area for improvement in relation to recording the date of opening on medicine containers to facilitate audit was identified.

The residents we met said that they were happy in the home and felt well cared for.

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	1

Details of the Quality Improvement Plan (QIP) were discussed with Mr Waldemar Mietlicki, 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.

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 30 August 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
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection

During the inspection we met with two residents, two support workers and the registered manager.

We provided one of the support workers with 10 questionnaires to distribute to residents and their representatives, for completion and return to RQIA. We left 'Have we missed you?' cards in the home to inform residents/their representatives, how to contact RQIA to tell us of their experience of the quality of care provided. Flyers providing details of how to raise concerns were also left in the home.

We asked one of the support workers to display a poster which invited staff to share their views and opinions 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
- care plans
- training records
- medicines storage temperatures

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 30 August 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 8 September 2016

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 support workers who have been trained and deemed competent to do so. Training was provided by both the registered manager and a representative of the community pharmacy. Competency assessments were completed annually or more frequently if a need was identified. Records were available for inspection.

In relation to safeguarding, the registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training was provided annually.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and to manage medication changes. Personal medication records and hand-written entries on the medication administration records were verified and signed by two support workers. This safe practice was acknowledged. The registered manager and support worker advised that medicine dosage regimens were confirmed with the prescriber before each period of respite care.

There were systems in place to ensure that residents had a continuous supply of their prescribed medicines. Discussion with staff indicated that antibiotics and newly prescribed medicines would be received into the home without delay.

Robust arrangements were observed for the management of high risk medicines e.g. insulin. Detailed care plans were in place and support workers had received training on the management of diabetes.

Satisfactory arrangements were in place for the safe disposal of discontinued or expired medicines.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. The medicine refrigerator was checked daily and satisfactory recordings were observed.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, medicine storage and the management of medication changes.

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 majority of medicines were supplied in a monitored dosage system and the audits completed indicated that these medicines had been administered as prescribed. Dates of opening had not been recorded on medicines which were supplied in their original packs and hence audits could not be completed. The date of opening should be recorded on all medicine containers in order to facilitate audit and disposal at expiry. An area for improvement was identified.

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. Care plans were in place and staff advised that the reason for and the outcome of administration were recorded on the reverse of the medication administration record and in the progress notes. There had been no recent administrations.

Regular pain relief was not prescribed for any residents. Staff advised that all residents could verbalise their pain and that pain relief was administered when required. The reason for and outcome of the administration was recorded. This good practice was acknowledged.

Staff advised that all residents were compliant with their prescribed regimes and that any ongoing refusals or omissions would be discussed with the resident and reported to the prescriber.

Medicine records were well maintained and facilitated the audit process. The allergy status of each resident was recorded on the personal medication records during the inspection. Staff were reminded that the date of writing should be recorded on personal medication records and that the time of administration should be recorded for any medicines which are administered outside the medicine round.

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. As detailed above, the date of opening should be recorded on all medicines to facilitate audit.

Following discussion with the registered manager and support workers, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in patient care.

Areas of good practice

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

Areas for improvement

The date of opening should be recorded on all medicine containers in order to facilitate audit and disposal at expiry.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

Arrangements were in place to facilitate residents responsible for the self-administration of medicines. The registered manager and support workers were familiar with the level of support provided to each resident. However, detailed care plans were not in place. The registered manager advised via email following the inspection that the relevant care plans had been updated to include all the necessary detail.

We did not observe the administration of medicines to any residents during the inspection. Support staff were aware of how/where each resident liked to take their medicines and this was facilitated to ensure compliance.

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.

We spoke with two residents. They were relaxing prior to lunch being served. They were complimentary regarding the care provided and staff in the home.

As part of the inspection process, we issued 10 questionnaires to residents and their representatives, none were returned within the specified time frame.

Any comments from residents and their representatives in questionnaires received after the return date (two weeks) will be shared with the registered manager for information and action as required.

Areas of good practice

Staff were observed to listen to residents and to take 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 the 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 in place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. They were not reviewed at the inspection.

Medicine related incidents reported since the last medicines management inspection were discussed and there was evidence of the action taken and learning implemented following these incidents. The registered manager advised that staff knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff advised that they were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were examined. We were advised of the auditing processes completed by both staff and management. Areas identified for improvement were detailed in an action plan which was shared with staff to address and there were systems in place to monitor improvement.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They advised that any concerns in relation to medicines management were raised with the registered manager.

The staff we met with spoke positively about their work and advised there were good working relationships in the home with staff and the registered manager. They stated they felt well supported in their work.

We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date.

No online questionnaires were completed by staff within the specified time frame (two weeks).

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 quality improvement plan (QIP). Details of the QIP were discussed with Mr Waldemar Mietlicki, Registered 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 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:** 11 January 2018	The registered person shall ensure that the date of opening is recorded on all medicines to facilitate audit and disposal at expiry. **Ref: 6.5**
	Response by registered person detailing the actions taken: Regular checks will be maintained to ensure that the date when all relevant medication is opened, a record will be made to facilitate audit and disposal.

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

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