Unannounced Medicines Management Inspection Report
19 November 2018

Seafort House

Type of service: Residential Care Home
Address: 6 Queen Street, Warrenpoint BT34 3HZ
Tel No: 028 4175 2200
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 13 residents with a learning disability.

3.0 Service details

Organisation/Registered Provider: Seafort House **Responsible Individual:** Mrs Rhoda Elizabeth McDonald	**Registered Manager:** Mrs Joanne McDonald
Person in charge at the time of inspection: Ms Annie Fitzpatrick, Senior Carer	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC): LD – learning disability LD(E) – learning disability – over 65 years	**Number of registered places:** 13

4.0 Inspection summary

An unannounced inspection took place on 19 November 2018 from 11.15 to 14.50.

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, medicine records, medicine storage and the management of controlled drugs.

No areas for improvement were identified at this inspection. The registered manager and staff are commended for their ongoing efforts.

We spoke with one resident who was complimentary regarding the care and staff in the home.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Annie Fitzpatrick, Senior Carer, as part of the inspection process and can be found in the main body of the report. Findings were also discussed with Mrs Joanne McDonald, Registered Manager, following the 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 9 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

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

During the inspection we met with three residents briefly, one care assistant, the activity therapist and the senior carer. We discussed the care provided in the home with one resident.

We provided 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 the senior carer 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
- medicines storage temperatures

The findings of the inspection were provided to the senior carer at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 9 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 23 August 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.

The registered manager advised that medicines were managed by staff who have been trained and deemed competent to do so. Training had been provided in June 2018. Competency assessments were completed annually or more frequently if a need was identified.

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 were verified and signed by two trained staff. This safe practice was acknowledged. The senior carer 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. There was evidence that antibiotics and newly prescribed medicines had been received into the home without delay.

Controlled drugs which required safe custody were not currently prescribed for any residents.

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. Dates of opening were recorded on limited shelf-life medicines to facilitate disposal at expiry. Safe systems were in place to manage the temperature of medicine storage areas.

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

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 examined had been administered in accordance with the prescriber's instructions. One discrepancy was highlighted to the senior carer and registered manager for close monitoring.

Three residents were 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 records. Staff advised that these were seldom used for the residents. 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 senior carer advised that the registered manager or deputy manager would be contacted prior to any administration and that the reason and outcome of administration would be recorded in the daily progress notes and medication notes.

Regular pain relief was not currently prescribed for any residents. The senior carer advised that all residents could verbalise any pain.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, care plans and speech and language assessment reports were in place. Records of prescribing and administration, which included the recommended consistency levels, were appropriately maintained.

The senior carer advised 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 well maintained and facilitated the audit process.

Practices for the management of medicines were audited throughout the month by the staff and management. This included daily stock counts for all medicines and a weekly audit of all medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the senior carer and care assistant, 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 resident 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

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.

Appropriate arrangements were in place to facilitate residents responsible for the self-administration of medicines.

We observed the administration of medicines to three residents at lunchtime. Two trained staff were involved in the administration. They engaged the residents in conversation and explained that they were having their medicines. The residents were happy to take their medicines.

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. It was clear from discussion and observation of staff, that the staff were familiar with the residents' likes and dislikes. Residents were observed to be relaxed and comfortable. They had enjoyed activities in the morning and were relaxing listening to the radio after lunch.

We spoke with one resident who was complimentary regarding the care provided and staff in the home. The resident was looking forward to going to see a play later in the evening and other planned outings over the rest of the week. Comments included:

"This is my new home. Everyone here is my friend and I like them very much. I am happy all the time. The food is lovely. The staff are great cooks."

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 respond promptly to all requests.

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 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 examined at the inspection.

There were robust arrangements in place for the management of medicine related incidents. The senior carer advised that she knew how to identify and report incidents. In relation to the regional safeguarding procedures, the registered manager advised that staff were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were examined. The senior carer advised of the auditing processes completed by both staff and management. Any areas identified for improvement were discussed with all staff for immediate implementation. 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. In addition to verbal handovers, a communications book was in use.

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 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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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