Unannounced Medicines Management Inspection Report
5 March 2018

Ard Cuan

Type of service: Residential Care Home
Address: 1 Demesne View, Portaferry, BT22 1QX
Tel No: 028 4272 8806
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 with 17 beds that provides care for residents with a range of care needs as detailed in Section 3.0

3.0 Service details

Organisation Ard Cuan **Registered Providers:** Mr James Caldwell & Mr William McClintock	**Registered Manager:** Mrs Frances Ann Mullan
Person in charge at the time of inspection: Mrs Frances Ann Mullan	**Date manager registered:** 21 September 2007
Categories of care: Residential Care Homes: DE – dementia I – Old age not falling within any other category	**Number of registered places:** 17 including: a maximum of 10 in category RC-DE

4.0 Inspection summary

An unannounced inspection took place on 5 March 2018 from 10.50 to 13.50.

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 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, storage and the management of controlled drugs.

No areas for improvement were identified.

The residents we spoke with were complimentary about the management of their medicines and the care provided 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 Mrs Frances Mullan, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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 18 October 2017. No further actions were required to be taken following this inspection. 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 incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

During the inspection the inspector met with three residents, the head of kitchen staff, the administrator, the senior carer and the registered manager.

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 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
- policies and procedures
- 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 October 2018

The most recent inspection of the home was an unannounced care inspection. There were no areas for improvement identified as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 11 February 2015

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 manager must ensure that a record is maintained of all medicines requested.	**Met**
	Action taken as confirmed during the inspection: A record of all medicines requested is now maintained.	
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 30 **Stated:** First time	The registered manager should ensure that two staff sign transcribed warfarin dosage directions.	**Met**
	Action taken as confirmed during the inspection: The registered manager confirmed that two staff sign transcribed warfarin dosage directions. Warfarin was not prescribed for any residents at the time of the inspection.	

Area for improvement 2 **Ref**: Standard 30 **Stated:** First time	The registered manager should ensure that records of staff competency assessments on the management of medicines are maintained.	**Met**
	Action taken as confirmed during the inspection: Competency assessments with regards to the management of medicines were completed annually. Records were available for inspection.	
Area for improvement 3 **Ref**: Standard 30 **Stated:** First time	The registered manager should review and revise the management of medicines which are to be administered when required for the management of distressed reactions as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The management of medicines which are prescribed to be administered "when required" for the management of distressed reactions had been reviewed and revised. Detailed care plans were in place. Records of prescribing and administration were clearly recorded. The reason for and outcome of administration were recorded in the daily progress notes.	

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. Training was completed via e-learning every two years. In addition training was provided by a representative of the community pharmacist annually. The impact of training was monitored through the audit process. Competency assessments were completed annually. All staff had received training on dysphagia and the use of thickening agents. The head of kitchen staff was due to attend swallow awareness training on 6 March 2018.

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 had been completed.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and discharge from the home.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. Hand-written entries on the medication administration records had not been verified and signed by two members of staff. The registered manager advised that all care staff would be made aware and that this would be closely monitored as part of her auditing system. Due to the assurances provided an area for improvement was not identified.

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.

Discontinued or expired medicines were returned to the community pharmacy for disposal.

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. The maximum, minimum and current refrigerator temperatures were monitored daily. Satisfactory temperature recordings were observed. It was agreed that the temperature of medicine storage areas would be monitored to ensure that the temperature is maintained at or below 25^{o}C.

Areas of good practice

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

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 been administered in accordance with the prescriber's instructions. There were arrangements in place to alert staff of when doses of twice weekly and weekly 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. Detailed care plans were in place. 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 recorded.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. The registered manager confirmed that all residents could verbalise their pain.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, care plans and up to date speech and language assessments were in place. Staff were aware of the current recommendations. However, details had not been recorded on the personal medication records and records of administration were not maintained. This was addressed during the inspection. The personal medication records were updated by two staff and a template to record each administration was developed by the administrator. The registered manager advised that records of administration would be maintained from the date of the inspection onwards. Due to the assurances provided an area for improvement was not identified.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on a resident's health were reported to the prescriber.

Medicine records were well maintained and facilitated the audit process. The registered manager was reminded that the date of writing should be recorded on personal medication records and that, as detailed in Section 6.4, hand-written updates on the medication administration records should be verified and signed by two members of staff.

Practices for the management of medicines were audited throughout the month by staff and management. This included running stock balances for inhaled medicines.

Following discussion with the registered manager and staff, 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.

The administration of medicines to residents had been completed prior to the commencement of this inspection and was not observed. Staff were knowledgeable about the administration of medicines and guidance was displayed on the medicines file for easy reference.

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.

The residents spoken to at the inspection, advised that they had no concerns in relation to the management of their medicines, they preferred the staff to administer their medicines and their requests for medicines prescribed on a 'when required' basis were adhered to e.g. pain relief. They were complimentary regarding staff and management. Comments included:

- "They do a wonderful job in here."
- "The manager is first class."
- "They couldn't do enough for you. The food is too good."

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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

Areas of good practice

Staff listened to residents 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.

Written policies and procedures for the management of medicines were in place. They were currently being reviewed by the registered manager.

The registered manager advised that there were robust arrangements in place for the management of medicine related incidents. In relation to the regional safeguarding procedures, the registered manager confirmed that staff 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.

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.

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.

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.

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care