Unannounced Medicines Management Inspection Report
2 June 2016

Ardview House

Address: 18 The Ward, Ardglass, BT30 7UP
Tel No: 028 4484 1093
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of Ardview House took place on 2 June 2016 from 10.20 to 13.15.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern and a quality improvement plan (QIP) has not been included in this report.

Is care safe?

The management of medicines supported the delivery of safe care. 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. There were no areas of improvement identified.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure residents were receiving their medicines as prescribed. Appropriate arrangements were in place for the management of pain. There were no areas of improvement identified.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely. Residents consulted with confirmed that they were administered their medicines appropriately. There were no areas of improvement identified.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. There were no areas of improvement 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	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Ms Siobhan Baker, Senior Care Assistant at the end of the inspection and with Ms Cathryn Canning, Registered Manager by telephone on 10 June 2016, and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last inspection on 28 April 2016.

2.0 Service details

Registered organisation/registered provider: South Eastern HSC Trust Mr Hugh Henry McCaughey	**Registered manager:** Ms Cathryn Anne Canning
Person in charge of the home at the time of inspection: Ms Siobhan Baker (Senior Care Assistant)	**Date manager registered:** 08 June 2015
Categories of care: RC-DE, RC-E, RC-MP(E), RC-PH, RC-TI, RC-I, RC-A	**Number of registered places:** 39

3.0 Methods/processes

Prior to inspection the following records were analysed:

- 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.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity.

We met with two residents and two care staff.

A sample of the following records was examined:

- 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 April 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP is due to be returned by 21 June 2016 and will be assessed by the care inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 17 June 2013

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 31 **Stated:** Second time	The registered person must ensure that, when entries are handwritten onto the MARs sheets, two staff members sign and verify the entry.	**Met**
	Action taken as confirmed during the inspection: This was observed to be routine practice within the home.	
Recommendation 2 **Ref**: Standard 30 **Stated:** First time	The registered person must ensure that there is a written policy and procedure detailing the arrangements for the management of thickening agents.	**Met**
	Action taken as confirmed during the inspection: Written guidance from the Speech and Language Therapy department on the management of dysphagia and thickening agents is provided for all staff. A sample of this guidance was provided following the inspection.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. The impact of training was monitored through supervision and annual appraisal. Competency assessments were completed annually. A sample of these records was provided by email following the inspection.

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.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two members of staff. This safe practice was acknowledged.

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.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in controlled drug record books. Checks were performed on controlled drugs which require safe custody, at the end of each shift.

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. It was noted that the maximum temperature of the refrigerator was slightly raised. The senior care assistant gave an assurance that she would have the temperature controls adjusted and that the temperature would be closely monitored.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

4.4 Is care effective?

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There was a discrepancy in the medicines for one resident. This was discussed with the senior care assistant. It was discussed and agreed that this discrepancy would be disseminated to staff for learning and closely monitored through the audit process.

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. 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 residents' health were reported to the prescriber.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included extra records for the administration of warfarin and protocols for residents who wished to self-administer medicines.

Practices for the management of medicines were audited monthly by the manager. These usually produced good outcomes. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the staff, it was evident that, when applicable, other healthcare professionals are contacted to meet the healthcare needs of residents.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	**0**	**Number of recommendations:**	**0**

4.5 Is care compassionate?

The administration of medicines to several residents was observed during the inspection. Medicines were administered to residents in the dining room with their lunch. The staff administering the medicines spoke to the residents in a kind and caring manner. Staff checked with residents whether medicines that were prescribed on a "when required" basis were required.

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were knowledgeable regarding their residents' needs, wishes and preferences. Staff and resident interaction and communication demonstrated that residents were treated courteously, with dignity and respect. Good relationships were evident.

Medicines management was discussed with a small number of residents. All responses were positive regarding the administration of medicines. Residents stated that they were given pain relief promptly when they requested them outside of the regular medicine rounds.

Self-administration of medicines was discussed. The senior care assistant advised that if residents were being discharged home, there would usually be a package of care that included help with medication. She advised that, when possible, residents would be given support for self-administration within the home prior to discharge.

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 medicines were in place.

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 staff, it was evident that they 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.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

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