Unannounced Medicines Management Inspection Report
27 June 2016

Balloo House

Type of Service: Residential Care Home
Address: 40 Donaghadee Road, Groomsport, BT19 6LH
Tel No: 028 9146 4430
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Balloo House took place on 27 June 2016 from 09.30 to 13.30.

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?

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. One recommendation has been made relating to the development of care plans for pain management.

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	1

Details of the QIP within this report were discussed with Mrs Shirley Ramrachia, 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 inspection

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/ registered provider: Balloo House/ Mr Chris Vijendra Ramrachia Mrs Shirley Ann Ramrachia	**Registered manager:** Mrs Shirley Ann Ramrachia
Person in charge of the home at the time of inspection: Mrs Shirley Ann Ramrachia	**Date manager registered:** 17 July 2012
Categories of care: RC-SI, RC-DE, RC-I	**Number of registered places:** 30

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned medicines management QIP
- 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 three residents, the registered manager and two care staff.

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

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent care inspection dated 24 October 2015

The most recent inspection of the home was an unannounced care inspection. There were no requirements or recommendations resulting from this inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 13 November 2014

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	The recording system in place for all residents who are prescribed 'when required' medicines for the treatment of agitation should include detailed care plans and the documentation of the reason for and outcome of administration.	**Met**
	Action taken as confirmed during the inspection: The recording system in place for residents who were prescribed 'when required' medicines for the treatment of agitation included detailed care plans and the documentation of the reason for and outcome of administration.	
Recommendation 2 **Ref**: Standard 30 **Stated:** First time	Running stock balances should be maintained for warfarin preparations.	**Met**
	Action taken as confirmed during the inspection: Running stock balances were maintained for warfarin preparations.	

Recommendation 3 **Ref**: Standard 30 **Stated:** First time	The prescribers should be requested to review those external medicines which, although prescribed for regular application, are being applied on a 'when required' basis.	**Met**
	Action taken as confirmed during the inspection: The prescribers were requested to review those external medicines which, although prescribed for regular application, were being applied on a 'when required' basis.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 4 **Ref**: Standard 30 **Stated:** First time	A record should be maintained of the annual review of staff medicines management competencies.	**Met**
	Action taken as confirmed during the inspection: A record was maintained of the annual review of staff medicines management competencies.	

4.3 Is care safe?

Medicines were managed by staff who had been trained and deemed competent to do so. An induction process was in place. The impact of training was monitored through team meetings, supervision and annual appraisal. The most recent medicines management training was provided by the community pharmacist in October 2015. Competency assessments were completed annually and were up-to-date.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Procedures were in place to identify and report any potential shortfalls in medicines. Robust arrangements were in place for ensuring supplies of acute prescriptions such as antibiotics were obtained and administered in a timely fashion.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were generally 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 and discharge from the home.

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 several other controlled drugs, which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturers' instructions. However, the controlled drugs cupboard was freestanding; the registered manager provided RQIA with confirmation that this issue had been addressed on 28 June 2016. 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 medicine refrigerator and oxygen equipment were checked at regular intervals. The medicine refrigerator digital thermometer had not always been reset after readings; the registered manager gave an assurance that this would be addressed.

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 mostly been administered in accordance with the prescriber's instructions. A small number of audit discrepancies were drawn to the attention of the registered manager, who gave an assurance that the administration of the medicines would be closely monitored to ensure compliance with the prescribers' instructions. 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 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, 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 recorded. A care plan was maintained. The registered manager stated that strategies to reduce distressed reactions were in place and it was acknowledged that these medicines were infrequently used.

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 pain was assessed as part of the admission process. A care plan was not maintained when a resident required analgesia on a regular basis; a recommendation was made.

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 mostly well maintained and facilitated the audit process. For one resident, two medicine entries on their personal medication record needed to be cancelled and rewritten in order to reflect the current dosage directions. Also, for several eye medicines, the route of application was not recorded on the personal medication records or medicine administration records. The registered manager gave an assurance that these matters would be addressed.

Practices for the management of medicines were audited monthly by a designated staff member and overseen by the registered manager. These audits had resulted in satisfactory outcomes. The dates and times of opening of the medicine containers were recorded in order to facilitate audit; this was acknowledged as good practice.

Following discussion with the registered manager and staff, it was evident that staff have good working relationships with other healthcare workers, including the community pharmacist and prescribers.

Areas for improvement

Where pain relief medication is prescribed on a regular basis, it should be referred to in a care plan. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

The administration of medicines to several residents was observed during the inspection. Medicines were administered to residents in their room or in the lounge. Staff administering the medicines spoke to the residents in a kind and caring manner and the residents were given time to swallow each medicine. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

The residents spoken to advised that they had no concerns in relation to the management of their medicines, and their requests for medicines prescribed on a “when required” basis was adhered to e.g. pain relief. They each spoke very positively about the care they received and advised that they were “well-cared for” and “very happy.”

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. Following discussion with staff, it was evident that they were knowledgeable of the policies and procedures and that any updates were highlighted to them.

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 satisfactory outcomes had been achieved.

Following discussion with the care staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that if there were any concerns in relation to medicines management they would be raised with the registered manager.

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

The issue identified during this inspection is detailed in the QIP. Details of this QIP were discussed with Mrs Shirley Ramrachia, 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 Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered provider may enhance service, quality and delivery.

5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to ***pharmacists@rqia.org.uk*** for review 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	
Recommendations	
Recommendation 1 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 27 July 2016	The registered provider should ensure that, where pain relief medication is prescribed on a regular basis, it is referred to in a care plan.
	Response by registered provider detailing the actions taken: Pain Assessment tools have been introduced into our Care Plan folders. Residents' pain relief requirements are now referred to in their Care Plans.

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