Camlo Homes
RQIA ID: 1585
3-5 North Parade
Belfast
BT7 2GF

Inspector: Cathy Wilkinson
Inspection ID: IN022463

Tel: 028 9064 5127
Email: johnston-wood5@hotmail.co.uk

Unannounced Medicines Management Inspection of Camlo Homes

18 November 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
Tel: 028 9051 7500 Fax: 028 9051 7501 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced medicines management inspection took place on 18 November 2015 from 11:40 to 14:00.

On the day of the inspection the management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no significant areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

This inspection was underpinned by The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

1.1 Actions/Enforcement Taken Following the Last Inspection

No further actions were required to be taken following the last inspection on 26 July 2012.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	4	1

The details of the QIP within this report were discussed with Mr Grant Johnston-Wood, Deputy Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Camlo Homes Mrs Lois Emerson Mr Stephen Emerson Mr Campbell Davis Emerson	**Registered Manager:** Mrs Joanne Smart
Person in Charge of the Home at the Time of Inspection: Mr Grant Johnston-Wood (Deputy Manager)	**Date Manager Registered:** 1 April 2005
Categories of Care: RC-PH, RC-PH(E), RC-A, RC-LD, RC-LD(E), RC-MP, RC-MP(E)	**Number of Registered Places:** 29
Number of Residents Accommodated on Day of Inspection: 25	**Weekly Tariff at Time of Inspection:** £470

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and to determine if the following standards and themes have been met:

Standard 30: Management of medicines
Standard 31: Medicine records
Standard 33: Administration of medicines

Theme 1: Medicines prescribed on a "when required" basis for the management of distressed reactions are administered and managed appropriately.

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

The management of medicine related incidents reported to RQIA since the previous medicines management inspection was reviewed.

We met with the deputy manager, Mr Grant Johnston-Wood and staff on duty.

The following records were examined:

Medicines requested and received	Medicine audits
Personal medication records	Policies and procedures
Medicine administration records	Care plans
Medicines disposed of or transferred	Training records
Controlled drug record book	Medicines refrigerator temperatures

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 5 November 2015. At the time of this inspection, the inspection report from that inspection had not yet been issued.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Inspection

The deputy manager advised that they had not received a report following the last medicines management inspection on 26 July 2012. A subsequent investigation by RQIA found that due to an oversight the report had not been issued to the home. Any requirements and recommendations discussed at the last inspection were re-examined at this inspection and where appropriate are detailed in the QIP attached to this report.

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

Systems were in place to ensure that sufficient medicines were available for each resident. All medicines audited during the inspection were available for administration.

In general, the audits which were completed at the inspection produced satisfactory outcomes indicating that the medicines had been administered as prescribed. Inhaled medicines are stored separately to other medicines. None of the inhaled medicines could be audited as the date of opening had not been recorded. Several of the inhalers were empty so no assurance could be provided that the residents were receiving their prescribed medication. Robust arrangements for the management of inhaled medicines must be implemented to ensure that these medicines are administered as prescribed. A requirement was made.

Robust arrangements were in place to ensure the safe management of medicines during a resident's admission or readmission to the home. The readmission of one resident following a stay in hospital was examined. The details recorded on the personal medication record corresponded to those on the hospital discharge letter.

Personal medication records were in place for each resident. Some improvements are necessary in the maintenance of the personal medication records. The date of prescribing and discontinuation must be recorded for each medicine. This information had not been recorded on most records examined. Each new entry on these records must be signed by the member of staff making the entry and should be verified by a second member of staff. Some of the entries made on these records, after the date of rewriting, had not been signed. On occasion the brand name of the medicine had been recorded on this record and the generic medicine was being administered. The generic name should be recorded if that is what is prescribed. A requirement in relation to personal medication records was made.

Most of the medication administration records had been maintained in a satisfactory manner. Two residents were regularly not receiving their prescribed medicines in the morning. The reason for these omissions was not always stated. Staff must ensure that the reason for not administering medicines is recorded on all occasions. If residents are regularly not taking doses of medicines, the general practitioner should be consulted. The staff on duty confirmed that the general practitioner had been informed. A requirement was made.

Is Care Effective? (Quality of Management)

Policies and procedures for the management of medicines and Standard Operating Procedures for the management of controlled drugs were available.

The senior residential worker advised that medicines were being managed by staff who had been trained and deemed competent to do so. Update training on the management of medicines was provided regularly. The senior residential worker confirmed that there was a system of regular supervisions and annual competency assessment.

There were systems in place to audit the practices for the management of medicines. The registered manager completed an audit approximately every two months.

There were procedures in place to report and learn from medicine related incidents that had occurred in the home. Any medicine incidents reported to RQIA had been managed appropriately.

Is Care Compassionate? (Quality of Care)

The records for a number of residents who were prescribed anxiolytic medicines for administration on a “when required” basis for the management of distressed reactions were examined. The parameters for administration were recorded on the personal medication records. Records of administration were in place. The medicines administration records indicated that the medicines were being administered in accordance with the prescribers’ instructions. Care plans were in place however, they did not always state which medicine was prescribed and the circumstances under which the medicines were to be administered. The reason for and outcome of administration had not been recorded. A recommendation was made.

The senior residential worker confirmed that residents had their pain management reviewed as part of the admission assessment. The senior residential worker advised that residents were able to tell staff when they required pain relief and that staff were knowledgeable in managing pain relief.

Areas for Improvement

Robust arrangements for the management of inhaled medicines must be implemented to ensure that these medicines are administered as prescribed. A requirement was made.

Personal medication records must be fully maintained and contain all of the necessary detail. A requirement was made.

Medicine administration records must be fully and accurately maintained. A requirement was made.

The management of medicines prescribed on a "when required" basis for the management of distressed reactions should be reviewed and revised to ensure that all appropriate records are maintained. A recommendation was made.

Number of Requirements:	**3**	**Number of Recommendations**:	**1**

5.4 Additional Areas Examined

At the time of the inspection, the refrigerator thermometer was not working. The most recent temperature recording that could be located was dated January 2015. On these records, it was observed that the temperature had not been recorded daily. In addition, the temperature recorded was outside of the required range of 2^{o}C to 8^{o}C. Medicines within the refrigerator included insulin. If this is not stored in accordance with the manufacturers' specifications it may affect the stability and efficacy. The registered person must put robust systems in place to ensure medicines are being stored at the correct temperature. A requirement was made.

Number of Requirements:	**1**	**Number of Recommendations**:	**0**

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr Grant Johnston-Wood, Deputy Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The DHPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Residential Care Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Person/Registered Manager

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to **pharmacists@rqia.org.uk** and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Statutory Requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be Completed by:** 18 December 2015	The registered person must ensure that robust arrangements for the management of inhaled medicines are implemented to ensure that these medicines are administered as prescribed.
	Response by Registered Person(s) Detailing the Actions Taken: The inhaled medication is kept in a locked cupboard adjacent to the oral medication. An audit trail is maintained of their use.
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time **To be Completed by:** 18 December 2015	The registered person must ensure that personal medication records are fully maintained and contain all of the necessary detail.
	Response by Registered Person(s) Detailing the Actions Taken: All Kardex's have been rewritten and will be reissued at the beginning of January 2016. All relevant information has been included.
Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time **To be Completed by:** 18 December 2015	The registered person must ensure that medicine administration records are fully and accurately maintained.
	Response by Registered Person(s) Detailing the Actions Taken: Medication recording sheets are being accurately maintained. Management monitor this.
Requirement 4 **Ref**: Regulation 13(4) **Stated:** First time **To be Completed by:** 18 December 2015	The registered person must put robust systems in place to ensure medicines are being stored at the correct temperature.
	Response by Registered Person(s) Detailing the Actions Taken: A new document is in place to record daily the fridge temperatures throughout the month.

Recommendations	
Recommendation 1 **Ref**: Standard 8 **Stated:** First time **To be Completed by:** 18 December 2015	The management of medicines prescribed on a “when required” basis for the management of distressed reactions should be reviewed and revised to ensure that all appropriate records are maintained. **Response by Registered Person(s) Detailing the Actions Taken:** When a resident requires such medication a record is made in their daily notes stating the reason they required it and how effective the medication was.

Registered Manager Completing QIP	Joanne Smart	**Date Completed**	16/12/16
Registered Person Approving QIP	Stephen Emerson	**Date Approved**	16/12/16
RQIA Inspector Assessing Response	Cathy Wilkinson	**Date Approved**	16/12/2015

Please ensure the QIP is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address