Unannounced Medicines Management Inspection Report
9 May 2016

Carmen House

Address: 3 Carmen Lane, Bangor, BT20 3PL
Tel No: 028 9145 9508
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of Carmen House took place on 9 May 2016 from 09.45 to 11.30.

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.

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 has not been included in this report.

Is care safe?
No requirements or recommendations have been made.

Is care effective?
No requirements or recommendations have been made.

Is care compassionate?
No requirements or recommendations have been made.

Is the service well led?
No requirements or recommendations have been made.

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 Mrs Patricia Millar, 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.

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 19 January 2016.

2.0 Service details

Registered organisation/registered person: Carmen House/ Mr Alexander Thomas Millar	**Registered manager:** Mrs Patricia Millar
Person in charge of the home at the time of inspection: Mrs Patricia Millar	**Date manager registered:** 20 September 2007
Categories of care: RC-DE, RC-I	**Number of registered places:** 15

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.

As well as the registered manager, we met with three residents and a senior care assistant.

The following records were 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 inspection dated 19 January 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 16 January 2014

There were no requirements or recommendations made as a result of the last medicines management inspection.

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for care staff. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in the management of medicines was provided in 2014.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. The registered manager 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. The registered manager advised that the residents' general practitioner would usually review their medicines twice a year.

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 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 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.

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 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, monthly or three monthly medicines were due.

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. The registered manager advised that the residents could verbalise any pain. A care plan was maintained.

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 well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included recording the therapeutic indication for each medicine on the personal medication records and on the MARs sheets and separate charts for the administration of external medicines.

Practices for the management of medicines were audited throughout the month by management. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and examination of care files, it was evident that when applicable, other healthcare professionals are contacted when appropriate to meet the healthcare needs of the 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?

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were knowledgeable regarding their resident's needs, wishes and preferences. Staff and resident interaction and communication demonstrated that residents were treated courteously, with dignity and respect. Good relationships were evident between staff and residents. A number of residents were observed to be enjoying a manicure during the inspection whilst others took the opportunity to sit in the sun.

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 medicines promptly when they requested them outside of the regular medicine rounds.

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. Management advised that these were reviewed regularly.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. The small number of medicine related incidents reported since the last medicines management inspection was discussed.

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 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 through team meetings.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements:	0	Number of recommendations:	0

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 person/manager from their responsibility for maintaining compliance with the regulations and standards.

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