Unannounced Medicines Management Inspection Report
7 June 2018

Carmen House

Type of service: Residential Care Home
Address: 3 Carmen Lane, Bangor, BT20 3PL
Tel No: 028 9145 9508
Inspector: Catherine Glover

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 15 beds that provides care for residents with a range of needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Carmen House **Responsible Individual:** Mr Alexander Thomas Millar	**Registered Manager:** Mrs Patricia Millar
Person in charge at the time of inspection: Ms Diane Young (Care Assistant)	**Date manager registered:** 20 September 2007
Categories of care: Residential Care (RC): I – old age not falling within any other category DE – dementia	**Number of registered places:** 15 Maximum of 2 residents in RC-DE (mild dementia) category of care

4.0 Inspection summary

An unannounced inspection took place on 7 June 2018 from 10.30 to 13.00.

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 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, storage and the management of controlled drugs.

Areas for improvement were identified in relation to personal medication records and ensuring records are maintained of contact with the resident's general practitioner.

Residents were relaxed and comfortable in the home. We noted the warm and welcoming atmosphere 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	2

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Patricia Curran, 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.

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 29 March 2018. Other than those actions detailed in the QIP no further actions were required to be taken. 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 two residents, the registered provider, the registered manager and two care assistants.

Ten questionnaires were provided for distribution to patients and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

A poster informing visitors to the home that an inspection was being conducted was displayed.

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

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 29 March 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 9 May 2016

There were no areas for improvement identified as a result of the last medicines management inspection.

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. An induction process was in place for care staff who had been delegated medicine related tasks. The impact of training was monitored through supervision and annual appraisal. Refresher training in medicines management was provided in the last 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.

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.

The arrangements in place to manage changes to prescribed medicines should be reviewed. On occasion, the newly prescribed medicines had not been recorded onto the personal medication record. The name and date had not always been recorded on the handwritten medicine administration sheet. An area for improvement has been made with regards to personal medication records in Section 6.5.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed and further training was planned in June 2018.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Staff were reminded that Schedule 3 controlled drugs must be stored in the controlled drugs cupboard. This was rectified during the inspection and staff discussed it with the community pharmacist to ensure that medicines are packaged to facilitate this storage requirement. As this issue was resolved an area for improvement was not specified.

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 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 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 medicines were due.

Improvements were required in the maintenance of the personal medication records:

- The process of verifying personal medication records for accuracy should be reviewed. The personal medication records were being generated by the community pharmacist. A copy of the prescription was emailed to the home however these were not being cross-referenced with the personal medication record. These records should be verified for accuracy and signed by two staff members.
- On occasion, newly prescribed medicines were not being added to the personal medication records and completed courses of tablets were not being discontinued on the record (See Section 6.4).
- The date of prescribing was not recorded.
- Several personal medication records were held on the medicines file. Only one up-to-date record should be in use at a time. Once the record is replaced, the obsolete record should be removed from the file and marked with the date of replacement.

An area for improvement was identified in relation to personal medication records.

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 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 resident's health were reported to the prescriber.

Following discussion with the registered manager and staff, it was evident that other healthcare professionals are contacted when required to meet the needs of residents. However, it was noted that a record of this contact had not been made with one resident's general practitioner. A record of all contact with healthcare professionals and the advice received should be made. An area for improvement was identified.

Areas of good practice

There were examples of good practice in relation to care planning and the administration of medicines.

Areas for improvement

Personal medication records must be fully and accurately maintained and the process of verifying the accuracy of the personal medication records should be reviewed and revised.

A record of all contact and advice from healthcare professionals involved in residents' care should be made.

	Regulations	Standards
Total number of areas for improvement	0	2

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 was observed during the lunch time medicine round. Staff were observed explaining what the medicine was and giving encouragement to residents. Staff were knowledgeable about residents' medicines and their preferences.

Throughout the inspection, it was found that there were good relationships between the staff, the residents and visitors, who were warmly greeted when they arrived. Staff were noted to be friendly and courteous. It was clear from discussion and observation of staff, that they were familiar with the residents' likes and dislikes.

We chatted generally to residents who were engaged in activities and games during the inspection. All residents seemed to be content and happy in the home.

None of the questionnaires that were issued were returned within the timescale for inclusion in this report (two weeks).

Any comments from residents, their representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for information and action as required.

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.

The inspector discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents. Arrangements are place to implement the collection of equality data within Carmen House.

Written policies and procedures for the management of medicines were in place. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the audit records indicated that satisfactory outcomes had been achieved, however it was not clear if the process would highlight a discrepancy should it occur. Advice was given on the audit process. The community pharmacist had completed audits on a quarterly basis.

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 the management team were open, approachable and willing to listen. Good relationships between staff and management were evident.

There were no replies to the staff on-line questionnaire.

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents 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

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Patricia Curran, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 7 July 2018	The registered person shall ensure that personal medication records are fully and accurately maintained and the process of verifying the accuracy of the personal medication records is reviewed and revised. Ref: 6.5
	Response by registered person detailing the actions taken: Kardex updated with dates for starting and discontinued medications, and 2 witness signatures. MAR sheets if hand written provide all necessary information on resident, including 2 signatures. Staff made aware of details that are vital in completing on reciept of new resident in the absent of manager.
Area for improvement 2 **Ref**: Standard 8 **Stated:** First time **To be completed by:** 7 July 2018	The registered person shall ensure that a record of all contact and advice from healthcare professionals involved in residents' care is made. Ref: 6.5
	Response by registered person detailing the actions taken: Contact and log booklet made up and put into action for all contact with professionals.

Please ensure this document is completed in full and returned via the Web Portal

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