The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report
10 January 2017

Clifton House Residential Home

Type of Service: Residential Care Home
Address: 2 North Queen Street, Belfast, BT15 1EQ
Tel no: 028 9089 7532
Inspector: Frances Gault

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Clifton House Residential Home took place on 10 January 2017 from 10.20 to 13.20.

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?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for residents. 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. No requirements or recommendations were made.

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. Two areas of improvement were identified in relation to record keeping and two recommendations were made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for residents. 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	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Frances McKernon, 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

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 16 June 2016.

2.0 Service details

Registered organisation/registered person: Clifton Care Home Ltd Ms Paula Reynolds	**Registered manager:** Mrs Frances McKernon
Person in charge of the home at the time of inspection: Mrs Frances McKernon	**Date manager registered:** 17 November 2016
Categories of care: RC-A, RC-LD, RC-PH, RC-I, RC-DE	**Number of registered places:** 27

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home

Prior to the inspection, 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, two care staff, the registered manager, one visiting professional and a relative.

Twenty-eight questionnaires were issued to staff, residents, relatives/ residents' representatives with a request that these were completed and returned within one week of the inspection.

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
- 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 16 June 2016

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.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 12 November 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	Staff competency in the management of medicines should be assessed and documented regularly. **Action taken as confirmed during the inspection**: The evidence seen indicated that there were suitable arrangements in place to assess and record staff competencies.	**Met**
Recommendation 2 **Ref**: Standard 30 **Stated:** First time	If medication is prescribed on a "when required" basis for the management of distressed reactions, the reason for and outcome of administration should be routinely recorded. **Action taken as confirmed during the inspection**: There was evidence that staff document the reason and outcome of administration.	**Met**

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 who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed. Refresher training in medicines management was provided by the registered manager in November 2016.

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 was evidence that confirmation was obtained from the general practitioner of the medicines currently prescribed when a resident was admitted to the home. A resident was admitted to the home during the inspection. Two staff were involved in checking the medicines into the home.

No schedule 2 controlled drugs are currently prescribed in the home. Checks were performed on other controlled drugs which require safe custody, at the end of each shift.

The community nursing team is responsible for the management of residents who are insulin dependent. They maintain care plans which direct staff to the action to be taken if there was a change to the health of the residents.

Discontinued or expired medicines were returned to the community pharmacy for disposal.

Medicines were stored safely and securely and in accordance with the manufacturer’s instructions. Medicine storage areas were clean, tidy and well organised. Medicine refrigerators and oxygen equipment were checked at regular intervals. The registered manager was reminded of the need to reset the medicine refrigerator each day. Staff advised of the action taken if the temperature was outside the recommended range.

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. 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.

When a resident was prescribed a medicine for administration on a “when required” basis for the management of distressed reactions, specific 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 registered manager advised that this is reinforced at any training attended in relation to dementia care. Specific care plans were not in place. The need to ensure that the rationale for the administration of these medicines was documented was discussed. A recommendation was made. The reason for and the outcome of administration were recorded. It was evidenced that some of the medicines were being administered regularly. Staff agreed to advise the prescriber of the increased frequency of administration.

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 a pain assessment tool was used when residents were prescribed analgesic medicines.

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.

The majority of the medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included recording the date of opening on all medicines not supplied in the monitored dosage system and documenting the amount carried forward at the end of the medicine cycle. The details of any known allergies were documented on the personal medication records but it was noted that staff did not record if there were no known allergies. A recommendation was made.

Following discussion with the registered manager and staff, and speaking with the community nurse, it was evident that, when applicable, other healthcare professionals were contacted in response to the health needs of the residents.

Areas for improvement

The rationale for the administration of medicines prescribed "when required" for the management of distressed reactions should be documented. A recommendation was made.

A statement in relation to the allergy status of each resident should be included on the personal medication record. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

No residents were currently responsible for the administration of their prescribed medication. One resident spoken with was being enabled to be actively involved in the management of their health condition. The resident spoke of their involvement in the process and knew of the importance of adhering to the dosage regime. They advised of their wish for more involvement and this was shared with the registered manager for consideration and discussion with the resident.

The administration of medicines to residents was completed in a caring manner, residents were given time to take their medicines and medicines were administered as discreetly as possible.

Twenty eight questionnaires were left in the home to facilitate feedback from residents, staff and relatives. Five were returned within the time frame from staff who advised that they were very satisfied with all aspects of the care in relation to the management of medicines. Three were returned from relatives who advised that they were satisfied/very satisfied with all aspects of the care in relation to the management of medicines.

Relatives commented:

"We were quite pro-active in the beginning asking questions a lot but we were reassured about XX's wellbeing and XX seems content".

"My mother would be unable to look after her meds".

A relative spoken with was positive in relation to the care delivered. She had expressed a concern to the registered manager earlier in the day and this was being dealt with positively.

Residents who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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. These were not examined during the inspection. Following discussion with staff it was evident that they were familiar with the policies and procedures.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. No medicine related incidents have occurred in recent years.

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. A summary of the latest audit activity was placed in the medicine folders to remind staff of any action required.

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.

The interactions between the staff and management during the inspection evidenced that any concerns or issues in relation to medicines management were freely discussed and a final outcome agreed. The discussions indicated an in depth knowledge of the needs of the residents.

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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Frances McKernon, 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 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 provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to *pharmacists@rqia.org.uk/* for assessment 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 10 **Stated:** First time **To be completed by:** 10 February 2017	The registered manager should ensure that the rationale for the administration of medicines prescribed "when required" for the management of distressed reactions should be documented. **Response by registered provider detailing the actions taken:** New document behavioural plan in place for all residents on medications for distress and agitation will be documented when they are given and reason why and if effective
Recommendation 2 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 10 February 2017	The registered manager should ensure that a statement in relation to the allergy status of each resident is included on their personal medication record. **Response by registered provider detailing the actions taken:** This has been completed on each residents medication record.A memo has also been placed in medication folders to ensure allergy status is updated monthly.

Please ensure this document is completed in full and returned to pharmacists@rqia.org.ukfrom the authorised email address*

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