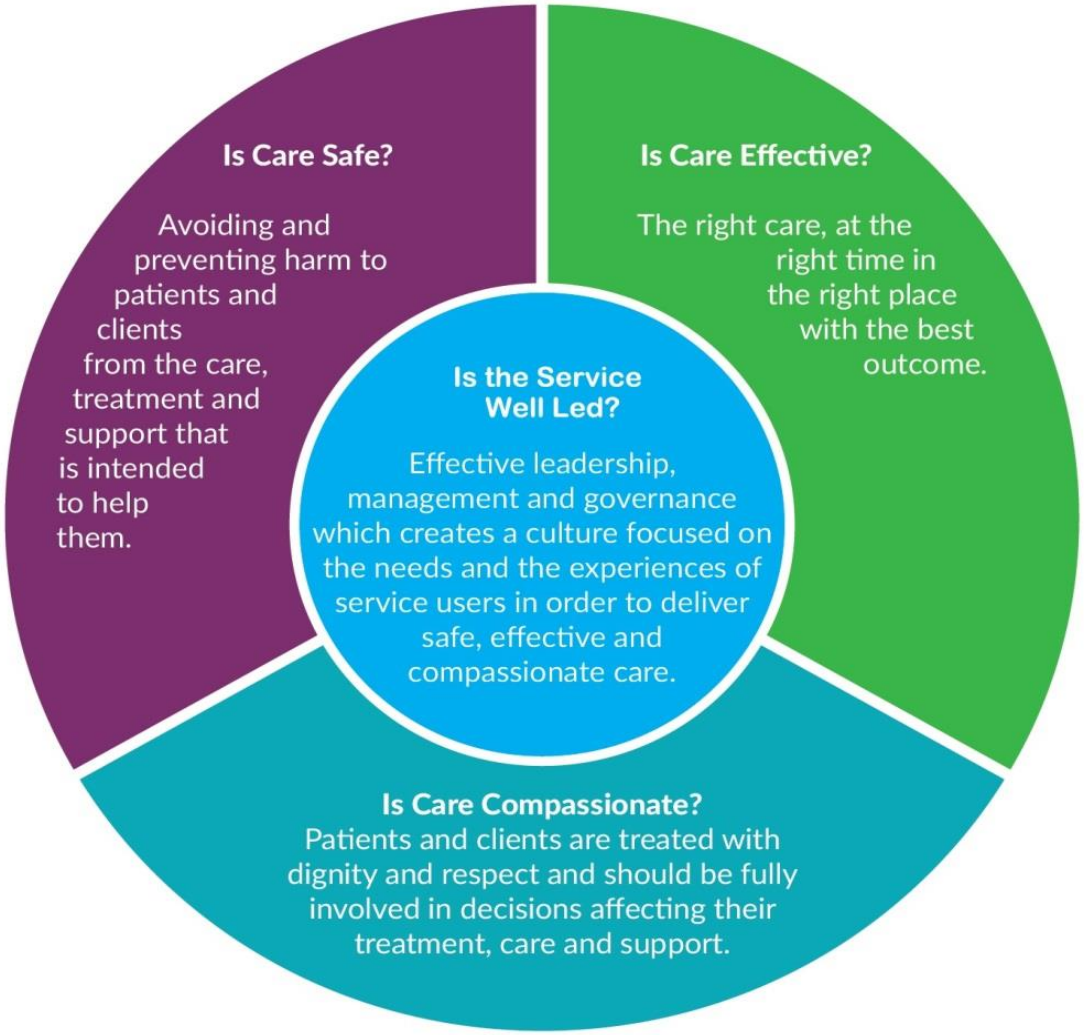
Unannounced Medicines Management Inspection Report
4 May 2018

Clifton House Residential Home

Type of service: Residential Care Home
Address: 2 North Queen Street, Belfast, BT15 1EQ
Tel No: 028 9089 7532
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 27 beds that provides care for residents with a variety of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Clifton Care Home Limited **Responsible Individuals:** Ms Paula Reynolds Mrs Fiona McAnespie (registration pending)	**Registered Manager:** Mrs Frances McKernon
Person in charge at the time of inspection: Mrs Frances McKernon	**Date manager registered:** 17 November 2016
Categories of care: Residential Care (RC) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. A – Past or present alcohol dependence.	**Number of registered places:** 27 Mild to moderate dementia in category RC-DE. RC-PH for one identified individual.

4.0 Inspection summary

An unannounced inspection took place on 4 May 2018 from 10.20 to 13.10.

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 during and 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 audit arrangements.

One area for improvement was identified in relation to the completion of personal medication records.

Residents were relaxed and comfortable in the home. There was a warm and friendly atmosphere.

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	1

Details of the Quality Improvement Plan (QIP) 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.

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 11 January 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 medicine related incidents reported to RQIA since the previous medicines management inspection.

During the inspection the inspector met with one resident, one senior care assistant, and the registered manager.

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

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

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

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 11 January 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 10 January 2017

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 10 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Care plans were maintained for those residents prescribed these medicines and the rationale for administration had been documented.	
Area for improvement 2 **Ref**: Standard 31 **Stated:** First time	The registered manager should ensure that a statement in relation to the allergy status of each resident is included on their personal medication record.	**Met**
	Action taken as confirmed during the inspection: The allergy status was recorded on the personal medication records.	

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. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was provided in the last year. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

There were procedures in place to ensure the safe management of medicines during a resident's admission to 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. Newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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. The medicine refrigerator was checked at regular intervals.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and the storage of medicines.

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 majority of medicines examined had been administered in accordance with the prescriber's instructions. Some minor discrepancies were highlighted to the registered manager who agreed to monitor these medicines through the routine audit process. There were arrangements in place to alert staff of when doses of weekly medicines were due.

Medicine records were generally well maintained and facilitated the audit process. However, the process of verifying personal medication records for accuracy should be reviewed. The personal medication records were being generated by the community pharmacist and emailed to the home. The home did not have a copy of the prescription to cross reference with the personal medication record. These records should be verified for accuracy and signed by two staff members. Updates to the record were also unsigned. This process should be reviewed and an area for improvement was identified.

When a resident was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the 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.

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.

Practices for the management of medicines were audited throughout the month by the staff and management. The outcome of the audit was shared with staff.

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. The registered manager reported that good relationships were maintained with visiting professionals.

Areas of good practice

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

Areas for improvement

The process of verifying the accuracy of the personal medication records should be reviewed and revised.

	Regulations	Standards
Total number of areas for improvement	0	1

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 not observed during this inspection, however 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 met with one resident, who expressed their satisfaction with the care and the staff in the home. They advised that they were administered their medicines on time. They were very complimentary about staff.

None of the questionnaires that were issued were returned from residents or relatives within the timeframe 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 manager for their 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.

Written policies and procedures for the management of medicines were in place. They were not reviewed during this inspection. Following discussion with staff it was evident that they were familiar with 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. 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 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.

None of the staff completed the online staff survey within the timeframe for inclusion in this report.

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 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 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:** 4 June 2018	The registered person shall ensure that 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: Immediate change of prescription sheets Planned regular changes to 4 presecription sheets Reflective practice session with senior staff re this inspection report on 14 May 18 Mediciation training with all relevant staff (17 May 18) Competency assessments commenced Monthly mediciation audits

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

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