Unannounced Medicines Management Inspection Report
22 November 2017

Corkey House

Type of service: Residential Care Home
Address: 1 Forthriver Crescent, Belfast, BT13 3SR
Tel No: 028 9071 8095
Inspector: Helen Daly

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

3.0 Service details

Organisation/Registered Provider: Presbyterian Council of Social Witness **Responsible Individual:** Mrs Linda May Wray	**Registered Manager:** See box below
Person in charge at the time of inspection: Mrs Rosemary Gilbey, Manager	**Date manager registered:** Mrs Rosemary Gilbey - registration pending
Categories of care: Residential Care (RC) I – old age not falling within any other category. DE – dementia. MP (E) - mental disorder excluding learning disability or dementia – over 65 years.	**Number of registered places:** 35 The home is approved to provide care on a day basis for two persons, a maximum of 10 existing residents in RC-DE category of care and a maximum of two existing residents in RC-MP (E) category of care.

4.0 Inspection summary

An unannounced inspection took place on 22 November 2017 from 10.15 to 14.25.

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, medicine records, medicines storage and the management of controlled drugs.

Areas requiring improvement were identified in relation to the management of thickening agents and the audit processes.

Residents comments included: “Care is great. You would not get better staff”.

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	1	1

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Rosemary Gilbey, 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 5 September 2017. 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 medication related incidents reported to RQIA since the last medicines management inspection

During the inspection we met with three residents, one care assistant, two senior carers and the manager.

A total of 10 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
- policies and procedures
- 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 5 September 2017

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 21 September 2015

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 31 **Stated:** Second time	Two designated members of staff should verify and sign all updates on the personal medication records.	**Met**
	Action taken as confirmed during the inspection: Examination of the personal medication records indicated that two senior carers now verify and sign updates 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 that have been trained and deemed competent to do so. An induction process was in place for care staff that had been delegated medicine related tasks. The manager had recently completed supervision with all staff. Competency assessments were completed annually. Update training had been requested from the community pharmacy recently. Due to the audit findings (See Section 6.5) the manager agreed to complete training and supervision with care staff on the administration of one liquid medicine and inhaler devices.

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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were mostly satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. This safe practice was acknowledged. A small number of handwritten entries on medication administration records had not been signed and verified by two senior carers, the manager advised that this would be followed up.

The manager confirmed that staff were aware of the regional procedures with regards to safeguarding and who to report any concerns to.

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. Additional checks were also performed on other controlled drugs which is good practice.

Mostly satisfactory arrangements were observed for the management of warfarin. The manager and senior carers were reminded that obsolete dosage directions (facsimiles) should be cancelled and archived.

Insulin was managed by the district nursing team. Care plans and the nursing team notes were available.

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. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. However the date of opening had not been recorded on a small number of eye preparations and Versatis plasters. It was acknowledged that this had been an oversight. The medicines refrigerator was checked each day.

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 majority of audits carried out at the inspection indicated that the medicines had been administered in accordance with the prescriber's instructions. However, significant audit discrepancies were observed for one liquid medicine and an inhaler device. These medicines should be included in the homes audits (see Section 6.7). It was agreed that the manager would contact the prescribers to report these observations after the inspection.

There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when weekly and twice weekly medicines were due.

Care plans were in place for residents who were 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 records. The reason for and the outcome of administration were recorded on the reverse of the medication administration records. 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 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 all residents could verbalise any pain. Care plans were maintained. Staff also advised that a pain assessment is completed as part of the admission process.

The management of swallowing difficulty was examined for two residents. Satisfactory systems were observed to be in place for one resident, a file containing their care plan and a copy of their speech and language assessment was in place. Records of administration were maintained. However, for the second resident, staff had been unable to determine the resident's requirements following a hospital discharge. The thickening agent had been prescribed in hospital. A referral had been made to the speech and language team and the prescriber had been consulted. Care assistants were administering the thickening agent but records of administration were not maintained. An area for improvement was identified.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the residents' health were reported to the prescriber.

Most of the medicine records were well maintained and facilitated the audit process. The personal medication records had recently been re-written. Areas of good practice were acknowledged which included separate records for the administration of transdermal patches. A small number of signatures for administration had been missed on the medication administration records and this was discussed for close monitoring.

Practices for the management of medicines were audited throughout the month by one senior carer, however, the findings of the inspection indicated that a more robust audit tool should be implemented, see Section 6.7. A quarterly audit was completed by the community pharmacist.

Following discussion with the manager and staff, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals involved in residents' care.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of most medicines.

Areas for improvement

The registered person shall ensure that accurate records of prescribing and administration are in place for thickening agents.

	Regulations	Standards
Total number of areas for improvement	1	0

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.

Appropriate arrangements were in place to facilitate residents responsible for the self-administration of medicines.

We observed the administration of medicines to several residents after lunch. The senior carers administering the medicines spoke to the residents in a kind and caring manner and the residents were given time to swallow their medicines.

Throughout the inspection, it was found that there were good relationships between the staff and the residents. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was clear from discussion and observation of staff, that the staff were familiar with the residents' likes and dislikes.

The residents spoken to at the inspection, advised that they had no concerns in relation to the management of their medicines, they preferred the senior carers to administer their medicines and their requests for medicines prescribed on a 'when required' basis were adhered to e.g. pain relief. They were complimentary regarding staff and management.

Comments included:

- "It's very good here; couldn't get better staff, it means a lot."
- "It's great here; the stew is lovely."
- "You wouldn't get kinder staff."

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Areas of good practice

Staff listened to residents and relatives 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.

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. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented. 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 small number of audits were completed at approximately monthly intervals. The findings of this inspection indicate that a more robust audit system should be implemented; the audit should include all aspects of medicines management in addition to audit trails. An area for improvement was identified.

Following discussion with the 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 that management were open and approachable and willing to listen.

Areas of good practice

There were examples of good practice in relation to the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

The registered person shall ensure that a robust audit tool is implemented. The audit should include all aspects of medicines management in addition to audit trails.

	Regulations	Standards
Total number of areas for improvement	0	1

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 Rosemary Gilbey, 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 Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 22 December 2017	The registered person shall ensure that accurate records of prescribing and administration are in place for thickening agents. Ref: 6.5
	Response by registered person detailing the actions taken: New recording sheets have been implemented. Speech & language reports are also now in residents file. Thickening agents now stored in the Treatment Room.
Action required to ensure compliance the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 22 December 2017	The registered person shall ensure that a robust audit tool is implemented. Ref: 6.5 & 6.7
	Response by registered person detailing the actions taken: The audits have been increased to weekly and any issues arising are investigated and adressed. Additional medicine trolley purchased.

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

The Regulation and Quality Improvement Authority

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