Unannounced Medicines Management Inspection Report
16 January 2019

Cranley Lodge

Type of service: Residential Care Home
Address: 5 Cranley Avenue, Bangor, BT19 7BY
Tel no: 028 9147 1122/ 9147 8006
Inspector: Rachel Lloyd

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 registered to provide care for up to 60 residents living with dementia.

3.0 Service details

Organisation/Registered Provider: Cranley Lodge **Responsible Individual:** Mr Brian Adam	**Registered Manager:** Mrs Elaine Thompson
Person in charge at the time of inspection: Mrs Elaine Thompson	**Date manager registered:** 14 September 2018
Categories of care: Residential Care (RC) DE – Dementia	**Number of registered places:** 60

4.0 Inspection summary

An unannounced inspection took place on 16 January 2019 from 10.00 to 14.00.

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

Areas for improvement were identified in relation to the management of inhaled medicines and care planning.

Residents were observed to be relaxed and comfortable in the home and good relationships with staff were evident.

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

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Elaine Thompson, Registered Manager and Mr Brian Adam, Responsible Individual, 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 3 and 6 July 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 last medicines management inspection

During the inspection the inspector met with two senior care assistants, the registered manager, the responsible individual and a director. We also met briefly with two residents.

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

A total of 10 questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. 'Have we missed you?' cards were left in the home to inform residents/their representatives of how to contact RQIA, to tell us of their experience of the quality of care provided. 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
- medicine 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 3 and 6 July 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was 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 17 May 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**
Recommendation 1 **Ref:** Standard 30 **Stated:** First time	The registered person should closely monitor the administration of inhaled medicines.	**Partially met**
	Action taken as confirmed during the inspection: Auditing of the administration of inhaled medicines had increased since the last medicines management inspection. However, discrepancies were observed for five of the preparations examined (see section 6.5). The possible reasons for these were discussed. These medicines should be given further attention within audit processes. This area for improvement was stated for a second time.	

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 senior care staff and for care staff who had been delegated medicine related tasks. The impact of training was monitored through observation, supervision and appraisal.

Training in medicine management and swallowing difficulties was provided in the last year. Competency assessments had been completed. Records were available for examination.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had taken place.

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. Antibiotics and newly prescribed medicines had been received into the home without delay.

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.

Satisfactory arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Appropriate arrangements were in place for administering medicines in disguised form.

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. Medicine refrigerators were checked at regular intervals.

Areas of good practice

There were examples of good practice in relation to staff training and competency assessment, the management of medicines at admission, changes to prescribed medicines and the management of controlled drugs.

Areas for improvement

No areas for improvement were identified.

	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 the sample of medicines examined had been administered in accordance with the prescriber's instructions. A few discrepancies were observed for inhaled medicines and the possible reasons for these were discussed. These medicines should be given further attention within audit processes (see Section 6.2). An area for improvement identified at the last medicines management inspection was stated for a second time. There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

When a resident was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, 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. However, care plans should be reviewed to ensure that they contain sufficient detail specific to the resident, to direct the staff as to when it may be appropriate to administer the prescribed medicines.

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 many of the residents could verbalise any pain. A care plan was maintained for some residents. Care plans should be reviewed to ensure that they contain sufficient detail specific to the resident, to direct the staff as to how pain is expressed and managed.

An area for improvement was identified in relation to care planning.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Administration was recorded and care plans and speech and language assessment reports were in place.

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.

Practices for the management of medicines were audited weekly by the staff and monthly by management. Audits were also completed by the community pharmacist. There was evidence that action was taken when any issues were identified.

Following discussion with the staff on duty and a review of the care plans, 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 the care of residents.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping and the administration of the majority of medicines.

Areas for improvement

Inhaled medicines should be given close attention within audit processes to identify the cause of the identified discrepancies. An area for improvement identified at the last medicines management inspection was stated for a second time.

Care plans should be reviewed and developed to ensure that they contain sufficient detail specific to the resident, to direct the staff as to how pain and/or distressed reactions are expressed and managed.

	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.

We observed the administration of medicines to a small number of residents. Staff interacted positively with the residents and explained that they were having their medicines.

Throughout the inspection, it was found that there were good relationships between the staff and the residents. It was clear from discussion and observation of staff, that the staff were familiar with the residents. 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. We spoke with two residents briefly who appeared relaxed and content in their environment but did not discuss the care provided or the management of their medicines.

Ten questionnaires were left in the home to facilitate feedback from residents and their representatives. None were returned within the specified timescale (two weeks).

Any comments received after the return date will be shared with the registered manager for information and action as required.

Areas of good practice

The administration of medicines to residents was completed in a caring manner and residents were given time to take their medicines.

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.

We 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 were in place to implement the collection of equality data.

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

There were arrangements in place for the management of any medicine related incidents. Staff confirmed that they knew how to identify and report incidents and 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. The area for improvement identified at the last medicines management inspection had not been addressed effectively. To ensure that this is fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Following discussion with the senior care staff on duty, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. We were advised that there were good communication systems in the home, to ensure that staff were kept up to date. Staff stated that management were approachable and listened to any concerns.

No online questionnaires were completed by staff within the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of identified 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 Elaine Thompson, Registered Manager and Mr Brian Adam, Responsible Individual, 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 30 **Stated:** Second time **To be completed by:** 16 February 2019	The registered person should closely monitor the administration of inhaled medicines. Ref: 6.2 & 6.5
	Response by registered person detailing the actions taken: Discussion took place with the Senior Care Staff in regards to accuracy of recording all administration of inhalers. Inhalers reviewed and replaced by GP where appropriate. An inhaler administration sheet devised and implemented for all inhalers within the medication trolleys. The senior in charge records the doseage administered. This sheet is then monitored and audited at regular intervals ensuring the accruacy of doseage administered.
Area for improvement 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 16 February 2019	The registered person shall ensure that care plans are reviewed and developed so that they contain sufficient detail specific to the resident, to direct the staff as to how pain and/or distressed reactions are expressed and managed. Ref: 6.5
	Response by registered person detailing the actions taken: are plans being reevaluated to contain accurate information regarding medical history, PRN drugs, reasons for prescribed medication and indicators for dispensing.. Kardex - When PRN medication is administered then the back of the Kardex Senior Care Staff will record the reasons for administration and outcome.

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

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