Unannounced Follow Up Medicines Management Inspection Report 5 June 2019

Cranley Lodge

Type of Service: Residential Care Home
Address: 5 Cranley Avenue, Bangor, BT19 7BY
Tel No: 028 9147 1122/ 028 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 provider 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 with care needs as detailed in Section 3.0.

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 Gillian Bradley (Director)	**Date manager registered:** 14 September 2018
Categories of care: Residential Care (RC) I – Old age not falling within any other category DE – Dementia	**Number of registered places:** 60 Including RC-I for one identified resident only

4.0 Inspection summary

An unannounced inspection took place on 5 June 2019 from 10.10 to 13.20.

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 sought to assess progress with the issues raised 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 regarding the management of medicines.

The following areas were examined during the inspection:

- the management of inhaled medicines
- care plans for the management of distressed reactions and pain

It was evidenced that the two areas identified for improvement at the last inspection had been addressed effectively.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Gillian Bradley, Director, as part of the inspection process and can be found in the main body of the report.

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 31 January 2019. 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 service 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.

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

During the inspection we met with a director of the organisation and two senior care assistants.

A sample of the following records was examined during the inspection:

- medicines received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- training records
- medicine audits
- medicine related care plans
- medicines storage temperatures
- controlled drugs records

Areas for improvements identified at the last medicines management inspection were reviewed and 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 31 January 2019

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 16 January 2019

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 30 **Stated:** Second time	The registered person should closely monitor the administration of inhaled medicines.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the administration of inhaled medicines was being monitored appropriately.	
Area for improvement 2 **Ref**: Standard 6 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A sample of these records was examined. There was evidence that care plans regarding the management of pain and distressed reactions had been updated and were evaluated on a regular basis. They included the necessary detail to reflect the resident's needs and direct the care of resident.	

6.3 Inspection findings

The management of inhaled medicines

All inhaler devices prescribed for use on a regular basis were checked and the balances remaining found to be correct. A running stock balance sheet was in place for each of these and was being spot-checked by senior staff and management.

Care plans for the management of distressed reactions and pain

A review of four resident's records indicated that medicines prescribed for use 'when required' were infrequently used in three of the examples. Where these were used more regularly there was evidence that this had been discussed with the prescriber. The reason for and the outcome of administration were recorded. Care plans were in place (see section 6.2).

A review of four care plans for residents prescribed regular and/or 'when required' analgesia were examined and found to contain sufficient detail to assist staff when administering these medicines (see section 6.2). Staff advised that if a resident could not communicate or verbalise pain then a pain assessment tool was put in place.

Other areas examined

The management of controlled drugs

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.

The completion of medicine records

As part of the inspection we reviewed the standard of record keeping regarding the prescribing and administration of medicines. These were well maintained and indicated that residents were being administered their medicines as prescribed.

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 senior care assistants.

The administration of thickening agents was examined for two residents and found to be satisfactory. Care plans were in place which correlated with the medicine prescribed and the speech and language assessment. Staff were advised to record the prescribed consistency of fluids on the personal medication record. It was agreed that this would be addressed immediately.

Staff training in the management of medicines

Staff training in relation to the management of medicines was provided by the community pharmacist in March 2019.

Storage and stock control of medicines

Satisfactory systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Antibiotics and newly prescribed medicines had been received into the home without delay.

Medicines were stored safely and securely and according to the manufacturer's instructions.

Medicines audits

Comprehensive audit systems were in place and audits were undertaken on a weekly basis by staff, these were overseen by management who complete a monthly audit. The community pharmacist also undertakes audits and provides advice periodically.

Areas of good practice

There was evidence of good practice in relation to the standard of record keeping, including controlled drugs, the storage of medicines, staff training and governance arrangements.

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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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