# Unannounced Medicines Management Inspection Report
# 10 January 2019

## Lawnfield House

**Type of service: Residential Care Home**
**Address: 5 King Street, Newcastle BT33 0HD**
**Tel No: 028 4372 6860**
**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 that provides care for up to 20 residents with a range of healthcare needs as detailed in Section 3.0. Care is provided on both a permanent and respite basis.

## 3.0 Service details

| | |
|---|---|
| **Organisation/Registered Provider:**<br>Presbyterian Council of Social Witness<br><br>**Responsible Individual:**<br>Mr Lindsay Conway - Registration pending | **Registered Manager:**<br>See box below |
| **Person in charge at the time of inspection:**<br>Ms Doreen Montgomery, Senior Carer | **Date manager registered:**<br>Mr Patrick Kerr – Acting - no application required |
| **Categories of care:**<br>Residential Care (RC):<br>SI – sensory impairment<br>I – old age not falling within any other category<br>LD – learning disability<br>LD(E) – learning disability – over 65 years<br>PH – physical disability other than sensory impairment<br>PH(E) - physical disability other than sensory impairment – over 65 years | **Number of registered places:**<br>20<br><br>The variation application has been granted on the basis that the accommodation is provided for residents in accordance with the letter dated 21 June 2013.<br><br>Category RC-SI is for two places only. |

## 4.0 Inspection summary

An unannounced inspection took place on 10 January 2019 from 10.00 to 12.15.

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 the management of controlled drugs.

Two areas for improvement were identified in relation to record keeping and recording dates of opening to facilitate audit and disposal at expiry.

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 |

Details of the Quality Improvement Plan (QIP) were discussed with Ms Doreen Montgomery, Senior Carer, and Mr Patrick Kerr, Manager, via telephone call (24 January 2019) 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 16 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

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

During the inspection we met with one senior carer.

We provided the person in charge with 10 questionnaires to distribute to residents and their representatives, for completion and return to RQIA. We left 'Have we missed you?' cards in the home to inform residents/their representatives, how to contact RQIA to tell us of their experience of the quality of care provided. Flyers providing details of how to raise concerns were also left in the home.

We asked the person in charge to display a poster which invited staff to share their views and opinions 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 storage temperatures
- medicines disposed of or transferred
- controlled drug record book

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 16 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 10 October 2016

| **Areas for improvement from the last medicines management inspection** | | |
|---|---|---|
| **Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005** | | **Validation of compliance** |
| **Area for improvement 1**<br><br>**Ref**: Regulation 13 (4)<br><br>**Stated:** First time | The registered provider must review and revise the management of controlled drugs as detailed in the report. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>The management of controlled drugs was reviewed and satisfactory systems were observed. Training had been provided for all senior carers following the last 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**<br><br>**Ref**: Standard 31<br><br>**Stated:** First time | When medicines are returned to the resident/their representative after each period of respite care a signature for the receipt should be obtained. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Senior carers now request the resident/their representative to sign the records of return. | |

## 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 senior carers who had been trained and deemed competent to do so. Training was provided annually by the community pharmacist. Competency assessments were also completed annually or more frequently if a need was identified. Training in medicines management was planned for 17 and 22 January 2019. Care assistants had received training and been deemed competent to administer thickening agents. Further training on the management of thickening agents was planned for March 2019.

In relation to safeguarding, the senior carer advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training was provided annually.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and to manage medication changes. However, not all personal medication records and hand-written entries on the medication administration records had been verified and signed by two trained staff. An area for improvement was identified in section 6.5.

There were systems in place to ensure that residents had a continuous supply of their prescribed medicines. There was evidence that antibiotics and newly prescribed medicines had been received into the home without delay.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Stock balance checks were performed on controlled drugs which require safe custody, at the end of each shift.

Satisfactory arrangements were in place for the safe disposal of discontinued or expired medicines.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. The senior carer advised that the medicines refrigerator was not working and that a new refrigerator was on order. There were no medicines which required cold storage on the day of the inspection.

**Areas of good practice**

There were examples of good practice in relation to staff training, competency assessment, the management of controlled drugs 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. However, some audits could not be completed as dates of opening had not been recorded. In order to facilitate audit and disposal at expiry, the date of opening should be recorded on medicine containers. One discrepancy in the administration of co-codamol tablets was observed. This was discussed in detail with the senior carer and manager for ongoing vigilance.

There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

The management of distressed reactions, pain and thickening agents was discussed. Staff advised that medicines for the management of distressed reactions were not currently prescribed for any residents. The senior carer advised that the management of pain was discussed at the start of each period of respite care and care plans were in place. Thickening agents were prescribed for some residents who received respite care. The senior carer advised that care plans and speech and language assessments were made available and shared with all staff (including kitchen staff) and that records of prescribing and administration were maintained when the residents were in the home.

Staff advised 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 records of receipt and disposal/return of medicines were well maintained and facilitated the audit process. However, improvements in the standard of maintenance of the personal medication records and medication administration records were necessary:

- Some details recorded on the personal medication records did not match those recorded on the medication administration records e.g. some discontinued medicines had not been cancelled. Entries on the personal medication records and medication administration records should correlate.
- When personal medication records had been written/replaced, they had not been signed by two trained staff. When newly prescribed medicines had been added to the personal medication records, the entries had not been signed by two trained staff. The personal medication records should be verified and signed by two trained staff at the time of writing and at each update.
- A number of obsolete personal medication records were observed on the medicines file. Obsolete personal medication records should be cancelled and archived.
- Hand-written entries on the medication administration records had not been verified and signed by two trained staff. Hand-written entries on the medication administration records should be verified and signed by two trained staff.

An area for improvement in relation to the maintenance of personal medication records and medicine administration records was identified.

Following discussion with the senior carer, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. The senior carer advised that they had good working relationships with healthcare professionals involved in resident care.

**Areas of good practice**

There were examples of good practice in relation to the standard of maintenance of records of receipt and disposal/return of medicines and the administration of medicines.

**Areas for improvement**

The date of opening should be recorded on all medicine containers to facilitate audit and disposal at expiry**.**

The necessary improvements should be made in the personal medication records and medication administration records.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 0 | 2 |

**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.**

Arrangements were in place to enable residents to self-administer medicines when appropriate.

We did not observe the administration of medicines to any residents during this inspection. The senior carer advised that medicines were administered safely to each resident in accordance with the residents' preferences.

At the start of the inspection care assistants were helping residents to get ready to go out for the morning as the weather was very good. One resident chose to remain in the home. The resident did not wish to meet with the inspector.

It was clear from discussion with the senior carer that she was familiar with the residents' likes and dislikes.

As part of the inspection process, we issued 10 questionnaires to residents and their representatives, none were returned within the specified time frame.

Any comments from residents and their representatives in questionnaires received after the return date (two weeks) will be shared with the manager for information and action as required.

**Areas of good practice**

Staff were observed to listen to residents and to take account of their views in relation to going out for the morning.

**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 the 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. The manager advised that arrangements were in place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. They were not reviewed at the inspection.

Medicine related incidents reported since the last medicines management inspection were discussed and there was evidence of the action taken and learning implemented following these incidents. The senior carer advised that staff knew how to identify and report incidents. In relation to the regional safeguarding procedures, the senior carer advised that staff were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were discussed with the manager who advised that weekly audits were carried out by the senior team. He advised that no issues had been identified through these audits. It was agreed that the auditing system would be reviewed and revised to ensure that all areas for the management of medicines, including those identified at this inspection, are included. Action plans to address any shortfalls should be developed and implemented. Due to the assurances provided an area for improvement was not stated on this occasion.

The senior carer advised that staff were familiar with their roles and responsibilities in relation to medicines management and that any concerns in relation to medicines management were raised with the manager.

The staff we met with spoke positively about their work and advised there were good working relationships in the home with staff and the manager.

We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date. In addition to verbal handovers, a communications diary was in use.

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 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 Ms Doreen Montgomery, Senior Carer, and Mr Patrick Kerr, 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**<br><br>**Ref**: Standard 30<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 February 2019 | The registered person shall ensure that the date of opening is recorded on all medicine containers to facilitate audit and disposal at expiry***.***<br><br>Ref: 6.5 |
| | **Response by registered person detailing the actions taken:**<br>All staff that are involved in the administration of medication have been made aware the importance of dating medication containers when opened, this was also highlighted in recent medication training. |
| **Area for improvement 2**<br><br>**Ref**: Standard 31<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 February 2019 | The registered person shall ensure that the necessary improvements are made in the standard of maintenance of the personal medication records and medication administration records.<br><br>Ref: 6.5 |
| | **Response by registered person detailing the actions taken:**<br>All staff that are involved in the maintenance of personal medication records will be given additional training in this area, this was also highlighted at the recent medication training. |

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

**Tel** 028 9536 1111
**Email** info@rqia.org.uk
**Web** www.rqia.org.uk
@RQIANews