Unannounced Medicines Management Inspection Report
29 June 2016

El Shammah

Type of Service: Residential Care Home
Address: 2 North Circular Road, Lisburn, BT28 3AH
Tel No: 028 9266 0617
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of El Shammah took place on 29 June 2016 from 09:20 to 12:20.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?
The management of medicines supported the delivery of safe care. Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. There were no areas of improvement identified.

Is care effective?
The management of medicines supported the delivery of effective care. There were systems in place to ensure residents were receiving their medicines as prescribed. One recommendation has been stated for the second time, relating to the development of care plans where 'when required' medicines are to be administered in the management of distressed reactions.

Is care compassionate?
The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely. Residents consulted with confirmed that they were administered their medicines appropriately. There were no areas of improvement identified.

Is the service well led?
The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. There were no areas of improvement identified.

This inspection was underpinned by 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).

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the QIP within this report were discussed with Mr Adrian McCready, 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.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last inspection on 1 March 2016.

2.0 Service details

Registered organisation/ registered provider: Amstecos Ltd/ Mrs Emer Bevan	**Registered manager:** Mr Adrian McCready
Person in charge of the home at the time of inspection: Mr Adrian McCready	**Date manager registered:** 9 September 2014
Categories of care: RC-I, RC-PH, RC-PH(E), RC-TI, RC-DE, RC-A, RC-MP(E)	**Number of registered places:** 35

3.0 Methods/processes

Prior to inspection the following records were analysed:

- 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 three residents, the registered manager and one member of care staff.

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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 1 March 2016

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 specialist inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 1 December 2014

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	The resident's care plan should include details of the circumstances under which 'when required' medicines are to be administered in the management of distressed reactions.	**Not Met**
	Action taken as confirmed during the inspection: For the two records examined, the care plan did not include details of the circumstances under which 'when required' medicines were to be administered in the management of distressed reactions. **The recommendation is stated for a second time.**	
Recommendation 2 **Ref**: Standard 31 **Stated:** First time	The disposals of controlled drugs should always be recorded in the controlled drug record book.	**Met**
	Action taken as confirmed during the inspection: The disposals of controlled drugs were recorded in the controlled drug record book.	

4.3 Is care safe?

Medicines were managed by staff who had been trained and deemed competent to do so. An induction process was in place. The impact of training was monitored through team meetings, supervision and annual appraisal. The most recent medicines management training was provided by the community pharmacist in July 2015. Competency assessments were completed annually and were up-to-date.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Procedures were in place to identify and report any potential shortfalls in medicines.

Robust arrangements were in place for ensuring supplies of acute prescriptions such as antibiotics were obtained and administered in a timely fashion.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medicine administration records were updated by two members of staff; this safe practice was acknowledged.

There were procedures in place to ensure the safe management of medicines during a resident's admission to 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.

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

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturers' 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 for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**	**0**

4.4 Is care effective?

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly, three monthly and six 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. A care plan was not maintained; a recommendation is stated for the second time. The registered manager stated that strategies to reduce distressed reactions were in place and it was acknowledged that these medicines were infrequently used.

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 pain was assessed as part of the admission process. A care plan was maintained when a resident required analgesia on a regular basis.

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.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some solid dosage medicines not contained in the monitored dosage blister packs. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that staff have good working relationships with other healthcare workers, including the community pharmacist, prescribers and community nursing services.

Areas for improvement

The resident's care plan should include details of the circumstances under which 'when required' medicines are to be administered in the management of distressed reactions. A recommendation is stated for the second time.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

The morning medication round had been completed before the commencement of the inspection. No medicines were observed to be administered to residents during the inspection.

During discussions with staff, we identified that residents were listened to and responded to by staff. Staff members were knowledgeable about the needs, preferences and abilities of individual residents.

The residents spoken to advised that they had no concerns in relation to the management of their medicines, and their requests for medicines prescribed on a "when required" basis was adhered to e.g. pain relief. They each spoke very positively about the care they received and advised that they were "well-cared for" and "very satisfied with the care provided."

Areas for improvement

No areas for improvement were identified during the inspection

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. Following discussion with staff, it was evident that they were knowledgeable of 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.

A review of the audit records indicated that satisfactory outcomes had been achieved.

Following discussion with the care staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management.

One recommendation made at the last medicines management inspection had not been addressed. To ensure that this recommendation is fully addressed and the improvement sustained, it was suggested that the report and QIP should be regularly reviewed as part of the quality improvement process.

Staff confirmed that any concerns in relation to medicines management were raised with management.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

The issue identified during this inspection is detailed in the QIP. Details of this QIP were discussed with Mr Adrian McCready, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the meets legislative requirements based on The Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions taken by the Registered Provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return the completed QIP to *pharmacists@rqia.org.uk* for review by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 30	The resident's care plan should include details of the circumstances under which 'when required' medicines are to be administered in the management of distressed reactions.
Stated: Second time **To be completed by:** 29 July 2016	**Response by registered provider detailing the actions taken:** The relevant care plans have been updated to include these medications. The manager will observe that this is reviewed as required. Staff have been reminded that care plans should be updated as required, to include details of the circumstances under which 'when required' medicines are to be administered in the management of distressed reactions.

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