Unannounced Medicines Management Inspection Report
21 February 2019

Fairhaven

Type of service: Residential Care Home
Address: 58 North Road, Belfast, BT5 5NH
Tel No: 028 9065 0304
Inspector: Judith Taylor

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 and accommodation for 36 residents living with care needs as detailed in Section 3.0 of this report.

The main building provides accommodation for up to 30 residents and there are two three bedded bungalows on the same site which can provide accommodation for up to six residents.

3.0 Service details

Organisation/Registered Provider: Fairhaven Residential Homes Ltd **Responsible Individual:** Mr James McElroy	**Registered Manager:** Mrs Elizabeth Sweetlove Orr
Person in charge at the time of inspection: Mrs Elizabeth Sweetlove Orr	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) LD – Learning disability LD(E) – Learning disability – over 65 years MP - Mental disorder excluding learning disability or dementia PH – Physical disability other than sensory impairment	**Number of registered places:** 36 including: • RC-PH – no more than 10 residents incorporating San Remo and Martinez Suites. • the home is also approved to provide care on a day basis only to three persons

4.0 Inspection summary

An unannounced inspection took place on 21 February 2019 from 10.00 to 15.00.

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 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 training, medicines administration, care planning and the storage of medicines.

Areas for improvement were identified in relation to audit and record keeping.

There was a warm and welcoming atmosphere in the home and the residents were observed to be relaxed and comfortable in their environment.

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	4

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Elizabeth Sweetlove Orr, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection undertaken on 13 December 2018. 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 incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

A poster was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

During the inspection we met with four staff and the registered manager.

We provided 10 questionnaires to distribute to residents and their representatives, for completion and return to RQIA and we asked the registered manager 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 received
- personal medication records
- medicine administration records
- medicines disposed of
- controlled drug record book
- medicine audits
- care plans
- training records
- medicines storage temperatures

We left ‘Have we missed you?’ cards in the home to inform residents and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

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 13 December 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 7 December 2016

There were no areas for improvement identified as a result of the last medicines management inspection.

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. The impact of training was monitored through team meetings, supervision and annual appraisal. Medicines training and competency assessments were completed annually. In relation to safeguarding, we were advised that staff were aware of the regional procedures and who to report any safeguarding concerns to.

Systems were in place to manage the ordering of prescribed medicines to ensure that residents had a continuous supply of their medicines. Staff advised of the procedures to identify and report any potential shortfalls in medicines.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home. The personal medication records were updated and signed by two trained staff. This is safe practice and was acknowledged.

The management of controlled drugs was reviewed. Robust arrangements were in place to ensure secure storage. Whilst no discrepancies were observed in the stock balances, the record keeping should be reviewed to ensure that the actual stock balance remaining is recorded and the record includes page numbers. We acknowledged that other controlled drugs which do not require storage in the controlled drug cupboard were being monitored regularly. We advised that the stock balance checks on these records should be documented

and signed by two staff. An area for improvement was identified. This was discussed with reference to their policies regarding controlled drugs and the minimum care standards.

The management of high risk medicines e.g. insulin was examined. A care plan was in place. Staff were not responsible for administration or blood monitoring; however, kept records of the insulin dose administered and the resident's blood glucose levels. This information was maintained for other healthcare professionals. The registered manager provided assurances that all staff were familiar with the signs and symptoms of changes in blood sugar levels and how to manage this.

Discontinued or expired medicines were returned to the community pharmacist for disposal.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean and tidy. In relation to the cold storage of medicines, there were systems in place to monitor the refrigerator temperatures.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment and the storage of medicines.

Areas for improvement

The record keeping in relation to controlled drugs should be reviewed.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. We noted discrepancies in a small number of medicines which were not supplied within the monitored dosage system. We also noted that some of these medicines were not dated when opened and we could not complete the audit. An area for improvement regarding audit was made in Section 6.7.

When a resident was 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 record. A care plan was maintained. 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. These medicines were rarely required and the registered manager advised that details of the reason for and the outcome of any administration would be recorded in the progress notes.

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 of the residents could tell staff if they were in pain.

The management of swallowing difficulty was examined. Details were recorded in a care plan and the speech and language assessment report was in place. When a thickening agent was prescribed, this was not recorded on the resident's personal medication record and a record of administration was not maintained. Staff were not aware that this was required and assured that this would be implemented without delay. It was agreed that this area of medicines management would be incorporated into their audit processes.

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.

Most of the medicine records were well maintained and facilitated the audit process. However, some improvements were found to be necessary. In relation to the completion of personal medication records, the date of writing should be recorded, a code for each medicine must be available and all external medicines and thickening agents must be included. Examination of the administration of medicines records indicated that the administration of some medicines was not documented, the time of administration of evening medicines was missing and we could not evidence that bisphosphonate medicines were administered separately from food or other medicines as stated by the manufacturer. Two areas for improvement were made.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to the residents healthcare needs.

Areas of good practice

There were examples of good practice in relation to the administration of most medicines.

Areas for improvement

The necessary arrangements should be made to ensure that personal medication records and medication administration records are fully and accurately maintained.

	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.

There were arrangements in place to facilitate residents who wished to self-administer some of their medicines. This was recorded in a care plan.

The administration of medicines was not observed at the time of this inspection. Staff advised that the residents were given time and encouraged when applicable to take their medicines. It was evident that the staff were knowledgeable regarding the residents' routines/preferences regarding medicines administration.

We noted the warm and welcoming atmosphere in the home. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was clear from observation of staff, that they were familiar with the residents' likes and dislikes.

Of the questionnaires that were issued for residents and their representatives, seven were returned within the specified time frame (two weeks). The responses indicated that they were very satisfied/satisfied with all aspects of the care in the home. Three comments were made:

- "I really like living here."
- "The staff are very kind and we do lots of fun things."
- "I like it here."

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.

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. These were not examined. The registered manager advised that all staff responsible for medicines had worked in the home for several years and were familiar with the policies; and also that a system was in place to ensure staff were made aware of any changes.

The governance arrangements for medicines were reviewed. The registered manager advised that audits were completed at six monthly intervals. As areas for improvement were identified in the domains of safe and effective care, the need for a robust audit system was discussed and an area for improvement was made. Advice was given and it was suggested that audits should be completed on at least on a monthly basis.

The management of medicines related incidents was examined. Staff knew how to identify and report incidents including referral to the safeguarding team if necessary.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns were raised with the registered manager.

The staff we met with spoke positively about their work and it was clear that there were good working relationships in the home with staff and management. They advised that there were effective communication systems in the home.

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

Areas of good practice

There were clearly defined roles and responsibilities for staff.

Areas for improvement

A robust auditing system which covers all aspects of medicines management should be developed and implemented.

	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 Elizabeth Sweetlove Orr, Registered 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 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 23 March 2019	The registered person shall ensure that the management of controlled drug records is reviewed as detailed in the report. Ref: 6.4
	Response by registered person detailing the actions taken: controlled drugs log book has been stock checked after each shift and quainty confirmed by 2 staff.pages have been numbered drugs locked in a safe cupboard with access by 2 staff and the key holder.
Area for improvement 2 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 23 March 2019	The registered person shall ensure that they review the completion of personal medication records to ensure that these are fully and accurately maintained. Ref: 6.5
	Response by registered person detailing the actions taken: medication sheets have been crossed matched with the marsh sheets and have been updated for any other medicines or creams used and signed with 2 signitures as per perscription 2 cardex files have been set up to keep records easy mainained
Area for improvement 3 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 23 March 2019	The registered person shall ensure that they review the completion of medication administration records to ensure that these are fully and accurately maintained. Ref: 6.5
	Response by registered person detailing the actions taken: medication sheets are being audited to ensure accurate strength and dosage as per prescription
Area for improvement 4 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 23 March 2019	The registered person shall develop and implement a robust auditing system for medicines management. Ref: 6.5 & 6.7
	Response by registered person detailing the actions taken: 2 audits have been carried out april and may audits will be done monthly to check quanities and signitures and stock of medication this is recorded and done random with all drugs

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

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