Unannounced Medicines Management Inspection Report
20 November 2018

Camphill Community Glencraig

Type of service: Residential Care Home
Address: 4 Seahill Road, Craigavad, Holywood, BT18 0DB
Tel No: 028 9042 3396
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 that provides care for up to 50 residents with a range of care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Camphill Community Glencraig **Responsible Individual:** Mr Vincent Reynolds	**Registered Manager:** See box below
Person in charge at the time of inspection: Mrs Deborah Rice	**Date manager registered:** Mrs Deborah Rice - Acting, no application required
Categories of care: Residential Care (RC): LD – Learning disability LD(E) – Learning disability – over 65 years	**Number of registered places:** 50 The maximum number of residents to be accommodated within individual houses is as follows: Bethany - seven Craigowen – five Comgall – three Dell O'Grace – four Emmaus House – seven Hermitage – three Kintyre – seven Novalis – six Parsifal – two Pestalozzi – one Samaria – four Ceridwen – one RQIA must be notified before any change in occupancy. The home is also approved to provide care on a day basis only for up to 13 persons.

4.0 Inspection summary

An unannounced inspection took place on 20 November 2018 from 10.20 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 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, the majority of medicine records, medicine storage and the governance and auditing arrangements.

One area for improvement was identified in relation to the maintenance of the personal medication records.

Residents were complimentary regarding the care provided and the staff in the home.

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	1

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Deborah Rice, 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 variation inspections

The most recent inspections of the home were announced care and premises inspections undertaken on 12 October 2018. Other than those actions detailed in the QIP (from the care inspection) no further actions were required to be taken. Enforcement action did not result from the findings of these inspections.

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
- 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 resident, one support worker, two senior carers, two group leaders and the manager.

We provided the manager 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 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 requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- medicine audits
- care plans
- training records
- medicines storage temperatures

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 inspections dated 12 October 2018

The most recent inspections of the home were announced care and premises inspections. There were no areas for improvement identified as a result of the premises inspection. The completed QIP, from the care inspection, was returned and approved by the care inspector.

6.2 Review of areas for improvement from the last medicines management inspection dated 23 February 2017

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.

The manager advised that all staff who manage medicines have received training and been deemed competent to do so. Staff attended medicines management training as part of their induction and then shadowed a trained member of staff until they had been deemed competent in the management and administration of medicines. Update medicines management training was provided every three years or more frequently if a need was identified. Supervisions were completed every six to eight weeks. Epilepsy awareness training was provided annually.

In relation to safeguarding, the manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training was provided as part of induction and annually thereafter.

The manager advised that there had been no recent admissions to the home. A review of recent medication changes indicated that updates on the personal medication records were not always verified and signed by two members of staff. An area for improvement regarding record keeping 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.

Detailed epilepsy management plans were in place.

Appropriate arrangements were in place for administering medicines in food/drinks to assist administration. Detailed care plans were in place and there was evidence of multi-disciplinary involvement.

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. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened.

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

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 sample of medicines examined had been administered in accordance with the prescriber's instructions.

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. 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 laminated copy of the care plans was available in the medicines file and the reason for and the outcome of administration were recorded.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. "When required" protocols for analgesia were in place. Pain assessment tools were in use and staff were aware of how each resident communicated.

The manager 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 majority of medicine records were well maintained and facilitated the audit process. The manager advised that the personal medication records were currently being re-written. The following improvements were necessary:

- a copy of the current prescription should be available for each resident for cross-referencing
- two trained staff should verify and sign the personal medication records at the time of writing and at each update i.e. medication/dosage change
- the date of writing should be recorded on the personal medication records
- obsolete personal medication records should be cancelled and archived

An area for improvement was identified.

Records of medicines received were not being maintained in one house which had recently changed to using a weekly monitored dosage system. It was acknowledged that this had been an oversight and that it would be put in place from the day of the inspection onwards. The medicines were due to be received the day after the inspection.

Practices for the management of medicines were audited throughout the month by staff and management. This included daily stock counts for all medicines and a weekly audit.

Following discussion with the manager and staff, 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 patient care.

Areas of good practice

There were examples of good practice in relation to the standard of most medicine records, care planning and the administration of medicines.

Areas for improvement

The registered person shall ensure that the improvements necessary in the personal medication records are implemented.

	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 did not observe the administration of medicines to any residents during the inspection. Discussions with the staff indicated that they were aware of how each resident liked to take their medicines.

Throughout the inspection, it was found that there were good relationships between the staff and the residents. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was clear from discussion and observation of staff, that the staff were familiar with the residents' likes and dislikes. Residents were observed to be relaxed and comfortable.

We spoke with one resident who was complimentary regarding the care provided and staff in the home. She advised that she was very happy in the home, was looking forward to coffee later with the manager and the celebrations planned for Christmas Eve.

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 and preferences.

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. They were not reviewed at the inspection.

There were robust arrangements in place for the management of medicine related incidents. 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. In relation to the regional safeguarding procedures, the manager advised that staff were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were examined. Management advised of the auditing processes completed by both staff and management. Areas identified for improvement were detailed in an action plan which was shared with staff to address and there were systems in place to monitor improvement.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They advised 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. They stated they felt well supported in their work.

We were advised that there were effective communication systems in the home, to ensure that all staff were kept up to date.

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 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 Deborah Rice, 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 29 **Stated:** First time **To be completed by:** 20 December 2018	The registered person shall ensure that the improvements necessary in the personal medication records are implemented. Ref: 6.4 and 6.5
	Response by registered person detailing the actions taken: - Medication Kardexes are now double signed, and stated on the top the "date effective from", as agreed with Inspector. - Old Kardexes are being archived and only current ones being held on file. - Medication deliveries are being taken note of within the identified house.

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