Unannounced Medicines Management Inspection Report
4 July 2016

Glenowen Court

Type of Service: Residential Care Home
Address: 177a Andersonstown Road, Belfast, BT11 9EA
Tel No: 028 9060 2898
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Glenowen Court took place on 4 July 2016 from 10.00 to 14.15.

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?

There was evidence that the management of medicines supported the delivery of safe care. Staff were trained and competent and there were robust processes for the management of medicines changes and management of high risk medicines. No requirements or recommendations have been made.

Is care effective?

There was evidence that the management of medicines supported the delivery of effective care. There were systems in place to ensure that the residents were administered their medicines as prescribed. Robust arrangements were in place for the management of pain. One recommendation in relation to care plans for distressed reactions has been made. No requirements have been made.

Is care compassionate?

There was evidence that the management of medicines supported the delivery of compassionate care. Where possible residents were involved in the management of their medicines and there was evidence of self-administration. Residents spoke positively of their care in the home and the management of their medicines. Staff interactions with residents were observed to be compassionate, caring and timely. No requirements or recommendations have been made.

Is the service well led?

There was evidence that the service was 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. There were robust systems to manage and share the learning from medicine related incidents and areas identified within the audit process. No requirements or recommendations have been made.

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 Mrs Siobhan Savage, Registered Manager and the senior care staff on duty, 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 estates inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 11 March 2016.

2.0 Service details

Registered organisation/ registered provider: Fold Housing Association Mrs Fiona McAnespie	**Registered manager:** Mrs Siobhan Savage
Person in charge of the home at the time of inspection: Mrs Siobhan Savage	**Date manager registered:** 2 November 2015
Categories of care: RC-DE, RC-LD, RC-LD(E), RC-SI, RC-MP, RC-MP(E), RC-I, RC-PH(E)	**Number of registered places:** 44

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.

We met with three residents, one member of care staff, two members senior care staff and the registered manager.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector. No one availed of the opportunity.
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 11 March 2016

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 20 November 2013

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 31 **Stated:** Second time	Policies and procedures for the management of self-administered medicines must be reviewed and updated. A protocol signed by the resident should be in place. A record should be maintained on each occasion a medicine is issued to a resident.	**Met**
	Action taken as confirmed during the inspection: Policies and procedures for the management of self-administered medicines had been reviewed. There was evidence of risk assessments and protocols signed by the resident. When a medicine was issued to the resident, this was recorded on the back of the medicines administration record. The registered manager advised by email after the inspection that a separate record book would be implemented to monitor compliance.	

Recommendation 2 **Ref**: Standard 31 **Stated:** First time	The registered manager should closely monitor the maintenance of medicine records as detailed in the report to ensure these are fully and accurately completed on every occasion.	**Met**
	Action taken as confirmed during the inspection: Medicines records were well maintained.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training was provided in the last year. This had included diabetes awareness, swallowing difficulty, the management of distressed reactions and general medicines management training.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines. It was noted that a small number of medicines were out of stock at the time of the inspection. This had resulted in some missed doses. Staff confirmed that the prescriber had been informed. They advised of the difficulty in obtaining these medicines and the action which had been taken regarding the contact made with the prescriber and the community pharmacy. The registered manager confirmed by email after the inspection on 4 July 2016 that a supply of these medicines was to be received by 5 July 2016.

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 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 the home 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. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. 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 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. Medicine refrigerators were 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?

With the exception of one inhaled medicine the sample of medicines examined had been administered in accordance with the prescriber's instructions. The discrepancy noted in the audit trail performed on the inhaled medicine was discussed and close monitoring was recommended. It was agreed that this finding would be reported to the residents' prescriber. The registered manager confirmed by email after the inspection on 4 July 2016 that the prescriber had been contacted and further advised by email on 5 July 2016 of the monitoring procedures that had been implemented after the inspection.

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 medicines were due.

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 not maintained and a recommendation was made. 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. The administration of these medicines was rarely required. There was evidence that the reason for and the outcome of one recent administration had been recorded.

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 the residents could verbalise any pain. They confirmed that the management of pain was reviewed as part of the admission process for new residents. The management of pain was referenced in a care plan.

The management of swallowing difficulty was examined. A care plan and speech and language assessment report were in place. However, the resident's personal medication record did not include the thickening agent or the prescribed consistency level of thickened fluid. It was agreed that this would be added to the record. When administered, a record was not maintained. Following discussion with the staff, it was evident that the resident's prescribed consistency level was known and could be easily referenced. The registered manager advised by email that a separate chart had been developed immediately after the inspection to record the administration.

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. Areas of good practice were acknowledged.

Practices for the management of medicines were audited throughout the month by the staff and management. A variety of medicines and formulations were audited and included a record of the weekly stock balance of several medicines e.g. tablets, capsules and sachets. This good practice was acknowledged. A specific audit focused on medicine records. In addition, a quarterly audit was completed by the community pharmacist.

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

Areas for improvement

The management of distressed reactions should be reviewed to ensure that a care plan is maintained. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

There were arrangements in place to facilitate residents who wished to self-administer their medicines. Risk assessments, protocols and records of the transfer of medicines to the resident were maintained. It was agreed that the resident's care plan would be updated to include reference to the medicines which were self-administered.

The administration of medicines to residents was observed during the inspection. The staff administered the medicines in a caring manner and residents were given time to take their medicines. There was evidence that medicines were administered in accordance with the residents' preferences in order to maintain dignity and privacy.

The residents spoken to at the inspection stated that they were content with their care in the home and had no concerns regarding the management of their medicines. They advised that staff responded in a timely manner to any requests for medicines e.g. pain relief. They spoke positively about the staff and comments included:

- "The staff are really good."
- "They look after me."
- "I would recommend this place."
- "Am content here."

Residents who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

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 familiar with the policies and procedures and that any updates were highlighted to staff.

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 internal audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

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

Staff advised that management were open and approachable and willing to listen. They stated that there were good working relationships within the home.

The recommendations made at the last medicines management inspection had been addressed.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated at the daily handover, through the use of the communication book and was shared individually with staff.

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

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Siobhan Savage, Registered Manager and the senior care staff on duty, 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 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 6 **Stated:** First time **To be completed by:** 4 August 2016	The registered provider should review the management of distressed reactions to ensure that a care plan is maintained for the relevant residents.
	Response by registered provider detailing the actions taken: Care plans have been developed and are being maintained as recommended.

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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