Unannounced Medicines Management Inspection Report
18 December 2017

Hollygate Lodge

Type of service: Residential Care Home
Address: 21 Hollygate Park, Carryduff, BT8 8DZ
Tel No: 028 9081 3243
Inspector: Catherine Glover

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 38 beds that provides care for residents with a range of needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Hollygate Care Services Ltd **Responsible Individual:** Mr Ian George Emerson	**Registered Manager:** Ms Sharon Boyd
Person in charge at the time of inspection: Ms Sharon Boyd	**Date manager registered:** 14 October 2015
Categories of care: Residential Care (RC) I – Old age not falling within any other category DE – Dementia MP – Mental disorder excluding learning disability or dementia LD(E) – Learning disability – over 65 years	**Number of registered places:** 38 Maximum of 12 persons in RC-DE (Mild) category of care; maximum of three named persons only in RC-LD (E) category of care and a maximum of one named person in RC-MP category of care.

4.0 Inspection summary

An unannounced inspection took place on 18 December 2017 from 10:30 to 13:40.

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 audits, medicines administration and medicine records.

One area for improvement has been stated for a second time regarding the management of medicines for distressed reactions.

Residents told us they were happy in the home and the staff were good.

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*

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Ms Sharon Boyd, 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 finance inspection

The most recent inspection of the home was an unannounced finance inspection undertaken on 13 October 2017. 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 incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

During the inspection the inspector met with four residents, one senior care assistant, the deputy manager and the registered manager.

Ten questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views 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
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

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 13 October 2017

The most recent inspection of the home was an unannounced finance inspection. A QIP was issued following this inspection. This QIP will be validated by the finance inspector at the next finance inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 7 and 24 July 2015

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 **Ref:** Regulation 13 (4) **Stated:** Second time	The registered manager must review and revise the management of external preparations. Records of prescribing and administration must be accurately maintained on all occasions.	**Met**
	Action taken as confirmed during the inspection: Records of the prescribing and administration of external preparations were satisfactory.	
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person must ensure that records for the administration of thickening agents are maintained.	**Met**
	Action taken as confirmed during the inspection: None of the current residents were prescribed thickened fluids. The registered manager and staff advised of the arrangements in place to ensure that staff recorded any administration when prescribed. Given these assurances this areas for improvement has been assessed as met.	

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 **Ref:** Standard 31 **Stated:** Second time	Two members of staff should verify and sign all updates on the medication administration records.	**Met**
	Action taken as confirmed during the inspection: Updates had generally been signed by two staff members.	
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time	It is recommended that Standard Operating Procedures for the management of controlled drugs are developed and implemented.	**Met**
	Action taken as confirmed during the inspection: Standard Operating Procedures had been developed and implemented.	
Area for improvement 3 **Ref:** Standard 30 **Stated:** First time	It is recommended that care plans for the management of distressed reactions are in place for residents when necessary. The outcome of the administration of "when required" medicines should be recorded.	**Partially met**
	Action taken as confirmed during the inspection: The reason and outcome of the administration of these medicines was recorded however care plans were not in place. This area for improvement has been stated for a second time.	

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. An induction process was in place for care staff. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was provided in the last year.

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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

There were procedures in place to ensure the safe management of medicines during a resident's admission to 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. One discrepancy was noted for a previously prescribed controlled drug and the registered manager advised that this would be addressed after the inspection. 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.

The management of warfarin was examined. Two staff members receive verbal confirmation of the dosage regime by telephone. Staff were advised to obtain written confirmation of the regime if possible and the registered manager advised that this would be discussed with the general practitioner.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. There is limited storage space for medicines in the home. 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 of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and controlled drugs.

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. 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. 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 reason for and the outcome of administration were recorded. A care plan was not in place and this area for improvement has been identified for a second time.

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. A care plan was maintained.

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. They included running stock balances for medicines not contained within the monitored dosage system

Practices for the management of medicines were audited throughout the month by the staff and management. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that other healthcare professionals are contacted when required to meet the needs of residents.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping and the administration of medicines.

Areas for improvement

No new areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

At the time of the inspection, a local school choir was singing Christmas carols in the residents' lounge. All residents were encouraged to attend. The senior care assistant advised that December had been a busy month of varied entertainment in the home which the residents had enjoyed.

The administration of medicines to residents was not observed during this inspection; however, staff were knowledgeable regarding residents' likes and dislikes.

Self-administration of medicines was discussed with the registered manager particularly with reference to those residents who were in receipt of short periods of respite care. The registered manager advised that this would be further considered.

One resident said, "Staff are very loving. I feel cared for which is important to me."

None of the questionnaires that were issued were returned within the timeframe for inclusion in this report.

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.

Written policies and procedures for the management of medicines were in place. Management advised that these were reviewed regularly. Following discussion with staff it was evident that they were familiar with the policies and procedures.

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. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the 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 confirmed that any concerns in relation to medicines management were raised with management.

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 Ms Sharon Boyd, 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 Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 30 **Stated:** Second time	It is recommended that care plans for the management of distressed reactions are in place for residents when necessary. The outcome of the administration of “when required” medicines should be recorded. Ref: 6.2
To be completed by: 18 January 2018	**Response by registered person detailing the actions taken:** Care plans for the management of distressed behaviours are now in place for the relevant residents. The outcome of the administration of 'when required' medicines will continue to be recorded in the daily log, and care plans will be updated regularly. In future, any resident prescribed medicine for distressed behaviour will have a care plan completed on the date the medication is prescribed.

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

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