Unannounced Medicines Management Inspection Report
13 June 2016

Loughview Fold

Type of Service: Residential Care Home
Address: 159a High Street, Holywood, BT18 9HU
Tel No: 028 9042 5117
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Loughview Fold took place on 13 June 2016 from 10.20 to 13.40.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern though several areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

Is care safe?

One recommendation has been made relating to confirming medication details with the prescriber for new admissions.

Is care effective?

Two recommendations have been made relating to the maintenance of care plans and the recording of the reason and outcome of administration for medicines prescribed on a "when required" basis for the treatment of distressed reactions.

Is care compassionate?
No requirements or recommendations have been made.

Is the service well led?

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**	**3**

Details of the QIP within this report were discussed with Mrs Helen Craig, 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 most recent inspection on 9 March 2016.

2.0 Service details

Registered organisation/registered provider: Fold Housing Association/ Mrs Fiona McAnespie	**Registered manager:** See box below
Person in charge of the home at the time of inspection: Mrs Helen Craig	**Date manager registered:** Mrs Helen Craig - application received - "registration pending".
Categories of care: RC-I, RC-DE	**Number of registered places:** 28

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

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 this opportunity.

We met with three residents and one senior care assistant.

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 9 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 care inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 12 November 2013

There were no requirements or recommendations made as a result of the last medicines management inspection.

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 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 in medicines management was provided within 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.

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

As part of the process of admitting a new resident to the home, the prescriber was not contacted to confirm medication details. A recommendation was made. The manager agreed to contact the prescriber to confirm the dosage directions for one medicine.

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 warfarin 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 temperature range of the medicine refrigerator was checked daily.

Areas for improvement

As part of the process of admitting a new resident to the home, the prescriber should be contacted to confirm the resident's medication details. A recommendation was made.

Number of requirements	0	Number of recommendations	1

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 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. A care plan was not maintained. The reason for and outcome of administration were not recorded. A recommendation was made.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff advised that there was ongoing monitoring to ensure pain was well controlled and the resident was comfortable. Staff also advised that most of the residents could verbalise any pain. Where pain relief medication was prescribed it was not referred to in a care plan; a recommendation was made.

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. The manager gave an assurance that only the current regulating anticoagulant treatment forms would be kept in the medicines kardex file.

Practices for the management of medicines were audited by the manager on a monthly basis. In addition, a quarterly audit was completed by the community pharmacist. The dates of opening were routinely recorded on medicine containers in order to facilitate audit activity; this good practice was acknowledged.

Following discussion with the manager and senior care assistant, it was evident that, when applicable, other healthcare professionals were contacted in response to issues or concerns in relation to medicines management.

Areas for improvement

When a resident is prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, a care plan should be maintained and the reason for and outcome of administration recorded. A recommendation was made.

Where pain relief medication is prescribed, it should be referred to in a care plan. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

The administration of medicines to several residents was observed during the inspection. Medicines were administered to residents in their room. Staff administering the medicines spoke to the residents in a kind and caring manner and the residents were given time to swallow each medicine. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

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 were adhered to e.g. pain relief.

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 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 manager and senior care assistant, it was evident that they were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that if there were any concerns in relation to medicines management they would be raised with the manager.

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 Helen Craig, 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 registered provider 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 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 assessment 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 **Stated:** First time **To be completed by:** 13 July 2016	The registered provider should ensure that, as part of the process of admitting a new resident to the home, the prescriber is contacted to confirm the resident's medication details.
	Response by registered provider detailing the actions taken: Confirmation of new residents medication received from GP on 13/6/16 ,all staff now aware to gain this information when admitting new residents.
Recommendation 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 13 July 2016	The registered provider should ensure that, when a resident is prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, a care plan is maintained and the reason for and outcome of administration is recorded.
	Response by registered provider detailing the actions taken: Care plans now updated to reflect this. . Two residents medication reviewed with GP and medication now discontinued. E Marr system now in use, all PRN medication administered has to have reason for giving, then follow up recorded detailing outcome of medication given.
Recommendation 3 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 13 July 2016	The registered provider should ensure that, where pain relief medication is prescribed, it is referred to in a care plan.
	Response by registered provider detailing the actions taken: Care plans have been updated to reflect this.

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