Unannounced Medicines Management Inspection Report
24 January 2019

Glenalina Lodge Care Centre

Type of service: Residential Care Home
Address: 607 Springfield Road, Belfast, BT12 7FN
Tel No: 028 9041 2030
Inspector: Rachel Lloyd

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

3.0 Service details

Organisation/Registered Provider: Care Circle Ltd. **Responsible Individual:** Mr Christopher Walsh	**Registered Manager:** See box below
Person in charge at the time of inspection: Mrs Catherine McDowell	**Date manager registered:** Mrs Catherine McDowell - acting manager - no application required.
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 MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH – Physical disability other than sensory impairment A – Past or present alcohol dependence SI – Sensory impairment	**Number of registered places:** 48 This number includes: • one named resident in category RC-SI • one named resident in category RC-A • six named residents in RC-DE • two named residents in RC-PH • a maximum of eight residents in category of care RC-MP and RC-MP(E)

4.0 Inspection summary

An unannounced inspection took place on 24 January 2019 from 10.50 to 14.25.

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 medicines administration, medicine records, medicine storage and the management of controlled drugs.

One area for improvement was identified in relation to care plans for the management of pain and distressed reactions.

Residents spoken to said they were happy in the home and with the care provided. They were observed to be relaxed and comfortable and good relationships with staff were evident.

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 Catherine McDowell, 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

The most recent inspection of the home was an unannounced care inspection undertaken on 12 June 2018. 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 medicine related incidents reported to RQIA since the last medicines management inspection

During the inspection we met with one senior care assistant, the manager, the activity therapist, a visiting barber (also a dementia friend) and briefly with a visiting community nurse. We also met with four residents.

A poster informing visitors to the home that an inspection was being conducted was displayed.

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
- medicine storage temperatures

A total of 10 questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. 'Have we missed you?' cards were left in the home to inform residents/their representatives of how to contact RQIA, to tell us of their experience of the quality of care provided. Staff were invited to share their views by completing an online questionnaire.

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 12 June 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 16 November 2016

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:** First time	The registered provider must ensure that medication administration records are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: The medication administration records examined during the inspection were accurately maintained.	

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 30 **Stated:** First time	The registered provider should ensure that the standard of maintenance of the controlled drug record book is monitored as part of the home's audit process.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the controlled drug record book was audited regularly within audit processes. There was evidence that action had been taken promptly to address any issues.	

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 senior care staff and for care staff who had been delegated medicine related tasks. The impact of training was monitored through observation, supervision and appraisal. Training in medicine management was provided in the last year, including the use of the new monitored dosage system, implemented in September 2018. Competency assessments were completed annually and the manager stated that these were due to take place week commencing 4 February 2019. Records were available for examination.

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

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home.

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.

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.

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. Staff were reminded to change the balance to zero following the return of controlled drugs to the community pharmacy for disposal.

Discontinued or expired medicines were disposed of appropriately. Some entries in the outgoing medicines record book stated "not needed" as the reason for disposal. Staff were advised to record the specific reason e.g. discontinued, refused etc. to facilitate audit.

Medicines were mostly stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and 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. Some creams were stored on top of and inside an unlocked medicines trolley in the office adjacent to the treatment room. The manager stated that this was not usual practice and these medicines were secured immediately. Staff were reminded that if this trolley is to be stored in the office then it must be secured to the wall and the room temperature should be monitored to ensure it remains at a maximum of 25°C. Staff were also reminded that the controlled drug cupboard key should be kept separate from other keys. This was addressed immediately.

Areas of good practice

There were examples of good practice in relation to staff training and competency assessment, the management of medicines at admission and changes to prescribed medicines.

Areas for improvement

No areas for improvement were identified.

	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 majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

When a resident was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, 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. The care plans reviewed did not provide sufficient detail specific to the resident to direct staff regarding the administration of these medicines.

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 many of the residents could verbalise any pain. A care plan was maintained for some residents. Care plans should be reviewed to ensure that they contain sufficient detail specific to the resident, to direct the staff as to how pain is expressed and managed.

An area for improvement was identified in relation to care planning.

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 discussed with the resident and reported to the prescriber as appropriate.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. These included the use of running balances for medicines not dispensed in the monitored dosage system and nutritional supplements and the maintenance of separate antibiotic records. Staff were reminded to take care when recording the names of medicines on personal medication records. Some medicines prescribed and dispensed generically were recorded using their brand name which may cause confusion. The manager agreed to address this following the inspection.

Practices for the management of medicines were audited weekly by the staff and monthly by management. Audits were also completed by the community pharmacist. There was evidence that action was taken when any issues were identified. Staff were reminded to record the date of opening on every medicine to facilitate audit. It was recorded for the majority of medicines examined.

Following discussion with the staff on duty and a review of the care plans, 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 the care 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

Care plans should be reviewed and developed to ensure that they contain sufficient detail specific to the resident, to direct the staff as to how pain and/or distressed reactions are expressed and managed.

	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.

The administration of medicines was not observed during the inspection. However, staff were observed to interact positively with the residents. Throughout the inspection, it was found that there were good relationships between the staff and the residents. It was clear from discussion and observation of staff, that the staff were familiar with the residents and their needs. Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Several residents were observed doing crafts in the lounge and two residents were playing cards with one of the two activity therapists on duty. Residents and staff were preparing for musical entertainment to be provided by a resident who spoke positively about the opportunity to play her guitar and sing with the residents and staff on a regular basis. Other residents spoke positively of these activities. We spoke to four residents who stated that they were happy in the home and with the care provided and the management of their medicines.

Ten questionnaires were left in the home to facilitate feedback from residents and their representatives. Nine were returned within the specified timescale (two weeks). The responses indicated that the respondents were “very satisfied” with all aspects of the care provided.

Any comments received after the return date will be shared with the manager for information and action as required.

Areas of good practice

Staff listened to residents 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 the 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.

Written policies and procedures for the management of medicines were in place. These were not examined. Following discussion with staff it was evident that they were familiar with policies and procedures and that any updates were highlighted to them.

There were arrangements in place for the management of any medicine related incidents. Staff confirmed that they knew how to identify and report incidents and medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents. 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 staff on duty, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management. We were advised that there were good communication systems in the home, to ensure that staff were kept up to date. Staff stated that management were approachable and listened to any concerns.

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 identified 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 Catherine McDowell, 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 6 **Stated:** First time **To be completed by:** 24 February 2019	The registered person shall ensure that care plans are reviewed and developed so that they contain sufficient detail specific to the resident, to direct the staff as to how pain and/or distressed reactions are expressed and managed. Ref: 6.5
	Response by registered person detailing the actions taken: All care plans for the named residents have been completed following the inspection. Distressed reaction care plans have been updated and include the information required so that staff can identify how the resident expresses pain and how we can manage the same. All senior staff have been advised of new care plans and care staff aware of how residents express pain and how to follow this up.

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

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