Unannounced Medicines Management Inspection Report
16 November 2016

Glenalina Lodge Care Centre

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

1.0 Summary

An unannounced inspection of Glenalina Lodge Care Centre took place on 16 November 2016 from 10.30 to 15.55.

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 and positive outcomes for residents. Staff administering medicines were trained and competent. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. One area for improvement in relation to the standard of record keeping for controlled drugs was identified. One recommendation was made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure residents were receiving their medicines as prescribed. One area of improvement in relation to accurate records of administration was identified and a requirement was made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for residents. Residents consulted with confirmed that they were administered their medicines appropriately. There were no areas of improvement identified.

Is the service well led?

The service was found to be 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. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. There were no areas of improvement identified.

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	1	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Peter Bradley, Acting 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 18 October 2016.

2.0 Service details

Registered organisation/registered person: Care Circle Limited Mr Christopher Walsh	**Registered manager:** Mr Peter Bradley – Registration Pending
Person in charge of the home at the time of inspection: Mr Peter Bradley (Acting Manager)	**Date manager registered:** Mr Peter Bradley – Registration Pending
Categories of care: RC-MP, RC-MP(E), RC-I, RC-A, RC-SI, RC-DE, RC-PH	**Number of registered places:** 47

3.0 Methods/processes

Prior to inspection we analysed the following records:

- 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 four residents, one care assistant, one team leader and the acting manager.

A number of questionnaires were issued to residents, relatives/residents' representatives and staff, with a request that they were returned within one week from the date of the inspection.

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 18 October 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be reviewed by the care inspector when it is returned. This QIP will be validated by the care inspector at the next care inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 21 October 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 30 **Stated:** Second time	The registered person should ensure that the outcome of each administration of medicines which are prescribed to be administered "when required" for the management of distressed reactions is recorded.	**Met**
	Action taken as confirmed during the inspection: A review of the records indicated that the reason for and outcome of administration were being recorded.	
Recommendation 2 **Ref:** Standard 30 **Stated:** First time	The registered person should closely monitor the administration of antibiotics.	**Met**
	Action taken as confirmed during the inspection: Stock balance sheets were being used to monitor the administration of antibiotics.	
Recommendation 3 **Ref:** Standard 30 **Stated:** First time	The registered person should ensure that detailed care plans for the management of distressed reactions and pain are in place for when necessary.	**Met**
	Action taken as confirmed during the inspection: Care plans for the management of distressed reactions and pain were in place.	

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 supervision and annual appraisal. Competency assessments were completed annually. Refresher training in the management of medicines had been provided by a representative of the community pharmacist in September and October 2016.

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 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. It was noted that two recent administrations of one controlled drug had not been recorded in the controlled drug record book. In addition some balances had not been brought to zero when controlled drugs were transferred out of the home. It was acknowledged that the administrations had been recorded in the medication administration records and that the transfers had been recorded in the returns books. The acting manager should monitor the standard of maintenance of the controlled drug record book as part of the audit process. A recommendation was made.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were returned to the community pharmacy for disposed.

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 and oxygen equipment were checked at regular intervals.

A number of valuable items belonging to residents, which had been deposited for safekeeping, were observed in the controlled drug cupboard. The identity of the owners was established during the inspection and they were moved to the home's safe. The acting manager advised that guidance on the safe keeping of personal items would be discussed with staff.

Areas for improvement

The acting manager should monitor the standard of maintenance of the controlled drug record book as part of the audit process. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

The majority of medicines examined had been administered in accordance with the prescriber's instructions. However, one audit discrepancy was identified and discussed in detail with the acting manager and team leader. It was agreed that this medicine would be closely monitored. The acting manager confirmed that safe handling precautions were observed for cytotoxic medicines and that written guidance would be provided for team leaders.

The acting manager and team leader confirmed that time critical medicines were 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. Care plans were in place. 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 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 most of the residents could verbalise any pain. Pain relief was observed to be offered at the medicines round. .

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the residents' health were reported to the prescriber.

Staff were reminded that the date of writing and allergy status should be recorded on all personal medication records.

Improvements in the standard of maintenance of the medication administration records were necessary. There were a number of random missed signatures for administration. For two medicines there had be no record of administration since the start of the new cycle (16 days). Examination of the blister packs indicated that the medicines had been administered. In addition the time of administration had not been recorded for some medicines. A requirement was made.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines, and inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the acting manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to medication related issues.

Areas for improvement

The registered provider must ensure that medication administration records are accurately maintained. A requirement was made.

Number of requirements	1	Number of recommendations	0

4.5 Is care compassionate?

Appropriate arrangements were in place to facilitate residents responsible for the self-administration of medicines when possible.

The administration of medicines to residents was completed in a caring manner, residents were given time to take their medicines and medicines were administered as discreetly as possible.

Residents advised that they were very happy in the home because:
“It is like a hotel.”
“Staff are very nice, they always ask you how you feel and if you want to talk.”
“You can ask for anything.”
“The staff ask you if you need painkillers.”

As part of the inspection process a number of questionnaires were issued to residents, relatives/residents’ representatives and staff, with a request that they were returned within one week from the date of the inspection. Three residents and two members of staff completed and returned the questionnaires. The responses were positive and these were recorded as “very satisfied” or “satisfied” with regard to the management of medicines in the home.

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 acting 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. They advised that any resultant action was communicated with staff either individually or via team meetings.

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 the QIP were discussed with Mr Peter Bradley, Acting 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 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 registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations 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

Statutory requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 16 December 2016	The registered provider must ensure that medication administration records are accurately maintained.
	Response by registered provider detailing the actions taken: Medication administration records are now audited daily by senior staff. Spot checks are also carried out by the acting manager.
Recommendations	
Recommendation 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 16 December 2016	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.
	Response by registered provider detailing the actions taken: The controlled drug book is now monitored as part of the homes audit process.

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