Glenalina Lodge Care Centre
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Unannounced Medicines Management Inspection of Glenalina Lodge Care Centre

21 October 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced medicines management inspection took place on 21 October 2015 from 10:30 to 13:30.

The management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no significant areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

This inspection was underpinned by the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

1.1 Actions/Enforcement Taken Following the Last Medicines Management Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the medicines management inspection on 3 November 2014.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	3

The details of the QIP within this report were discussed with Mrs Anna McKinnon, Senior Carer, as part of the inspection process. The outcomes of the inspection were also discussed with Mrs Paula Kennedy, Registered Manager, via telephone call on 23 October 2015. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Care Circle Limited Mr Ciaran Henry Sheehan	**Registered Manager:** Mrs Paula Kennedy
Person in Charge of the Home at the Time of Inspection: Mrs Anna McKinnon, Senior Carer	**Date Manager Registered:** 23 May 2013
Categories of Care: RC-MP, RC-MP(E), RC-I, RC-A, RC-SI, RC-DE, RC-PH	**Number of Registered Places:** 47
Number of Residents Accommodated on Day of Inspection: 43	**Weekly Tariff at Time of Inspection:** £470 - £528

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and to determine if the following standards and themes have been met:

Standard 30: Management of medicines
Standard 31: Medicine records
Standard 33: Administration of medicines

Theme 1: Medicines prescribed on a "when required" basis for the management of distressed reactions are administered and managed appropriately.

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately.

As part of the inspection adherence to dosage intervals and the management of warfarin were examined due to recent whistleblowing information.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to the inspection, we reviewed the management of medication related incidents reported to RQIA, since the last medicines management inspection.

We met with the senior carer in charge, Mrs Anna McKinnon.

The following records were examined:

- Medicines requested and received
- Personal medication records
- Medicines administration records
- Medicines disposed of or transferred
- Controlled drug record book
- Medicine audits
- Policies and procedures
- Care plans
- Training records

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection on 12 May 2015. The returned QIP was approved by the care inspector on 22 July 2015.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Monitoring Inspection

Last Inspection Statutory Requirements		**Validation of Compliance**
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered manager must investigate why hydroxyzine 25mg tablets had been out of stock and what action staff had taken to obtain this medicine. A report of the findings must be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: The investigation was completed and an action plan to prevent a recurrence was submitted to RQIA.	
Last Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref:** Standard 30 **Stated:** First time	The registered manager should ensure that the reason for and outcome of each administration of medicines which are prescribed to be administered when required for the management of distressed reactions is recorded.	**Partially Met**
	Action taken as confirmed during the inspection: A review of the records indicated that the reason for each administration had been recorded. However, the outcome of each administration had not been recorded. Part of this recommendation has therefore been stated for the second time.	

Recommendation 2 **Ref**: Standard 32 **Stated:** First time	The temperature of the treatment room should be monitored and recorded each day to ensure that it is maintained at or below 25^{o}C.	**Met**
	Action taken as confirmed during the inspection: The temperature of the treatment room had been recorded each day and was below 25^{o}C.	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

The majority of the audits which were carried out on a range of randomly selected medicines produced satisfactory outcomes, indicating that the medicines had been administered as prescribed. A small number of minor discrepancies were discussed with the senior carer. Significant discrepancies were observed in the patterns of administration of two antibiotics. There was no evidence that action was taken when doses were delayed/omitted.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. All medicines were available for administration on the day of the inspection. Medicines were observed to be labelled appropriately.

One senior carer was responsible for administering medicines to the residents. The medicine round was completed by approximately 10.50. The member of staff on duty advised that staff observed the prescribed dosage intervals and this was also confirmed by the entries on the administration records. The registered manager advised, after the inspection, that procedures had been reviewed and two senior carers would carry out the morning medication round from 26 October 2015 onwards.

Arrangements were in place to ensure the safe management of medicines during a resident's admission to the home. The admission process was reviewed for a number of recently admitted residents. Their medicine regimes had been confirmed in writing. Two trained staff had verified and signed the personal medication records.

Diabetes management plans were in place for designated residents. In addition clear documentation on how to manage hypoglycaemia was available in the treatment room. The senior carer advised that the general practitioner would be contacted if high blood glucose readings were noted.

The management of warfarin was reviewed and found to be satisfactory. Dosage directions were received in writing and running stock balances were maintained. The audit which was completed on warfarin tablets produced a satisfactory outcome.

Medicine records had been maintained in a mostly satisfactory manner; staff were commended for their ongoing efforts. However, the date of writing, allergy status and strength of medicines had not been recorded on a small number of the personal medication records. The month and year of administration had not been recorded on some recent hand-written medication administration records.

Records showed that discontinued and expired medicines had been returned to the community pharmacy. Two staff were involved in the disposal of medicines and both had signed the records of disposal.

There were no Schedule 2 controlled drugs in use on the day of the inspection. Robust systems were in place for the management of controlled drugs in Schedule 3 and Schedule 4 (Part 1). Stock reconciliation checks were completed at shift handovers.

Is Care Effective? (Quality of Management)

Policies and procedures for the management of medicines, including Standard Operating Procedures for the management of controlled drugs, were available in the treatment room.

There was evidence that medicines were being managed by senior carers who had been trained and deemed competent to do so. Update training on the management of medicines had been provided by the community pharmacist. Records were provided for inspection.

The senior carer advised that guidance on the management of diabetes and the use of blood glucometers had been provided by the diabetes specialist nurse.

There were a number of auditing systems. Accurate running stock balances were maintained for several medicines. Audits on the management of medicines prescribed for two residents were also completed by the night staff each night. In addition the registered manager completed a regular audit on the management of warfarin, controlled drugs and refrigerator temperatures. There was evidence that corrective action was taken when shortfalls were identified. The registered manager acknowledged that ongoing auditing was necessary to drive and sustain improvement.

There were procedures in place to report and learn from medicine related incidents that have occurred in the home. The medicine incidents reported to RQIA since the last medicines management inspection had been managed appropriately.

Is Care Compassionate? (Quality of Care)

There was evidence that residents who had requested to self-administer their medicines were facilitated to do so. Safe systems were observed.

The records for a number of patients who were prescribed anxiolytic medicines for administration on a “when required” basis for the management of distressed reactions were examined. Records of prescribing and administration were in place. Care plans were also in place but these did not provide detail on how the residents expressed their distressed reactions. The reason for each administration had been recorded on the reverse of the medication administration records however the outcome of each administration had not been recorded.

The senior carer advised that pain management was discussed with residents and their families as part of the admission process. The reason for and outcome of administration of analgesics were recorded on the reverse of the medication administration records. These records were then evaluated monthly and any increased usage was referred to the prescribers for review. The senior carer advised that not all residents could verbalise when they were in pain but that staff were familiar with identifying indicators of pain. Care plans were not in place.

Areas for Improvement

The registered manager 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. Part of a recommendation was made for a second time.

The registered person should closely monitor the administration of antibiotics. A recommendation was made.

The registered person should ensure that detailed care plans for the management of distressed reactions and pain are in place when necessary. A recommendation was made.

The registered manager agreed to continue to closely monitor the standard of record keeping to ensure that the date of writing, allergy status and strength of medicines, are recorded on all personal medication records and the month and year of administration are recorded on all hand-written medication administration records.

Number of Requirements:	**0**	**Number of Recommendations**:	**3**

5.4 Additional Areas Examined

Storage was observed to be tidy and organised. The registered manager and staff are commended for their ongoing efforts.

In use insulin pens were observed in the refrigerator and the date of opening had not been recorded on a number of medicine containers. The senior carer was reminded that insulin in use should be stored at room temperature and that the date of opening should be recorded on all medicines.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Anna McKinnon, Senior Carer, on the day of the inspection and with Mrs Paula Kennedy, Registered Manager, via telephone call, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Residential Care Homes Regulations (Northern Ireland) 2005.

6.2 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 person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Person/Registered Manager

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to **pharmacists@rqia.org.uk** and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref:** Standard 30 **Stated:** Second time **To be Completed by:** 20 November 2015	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.
	Response by Registered Person(s) Detailing the Actions Taken: The Manager actioned this issue by holding a meeting with all designated staff in order to highlight the importance of recording the management of distressed reactions.
Recommendation 2 **Ref:** Standard 30 **Stated:** First time **To be Completed by:** 20 November 2015	The registered person should closely monitor the administration of antibiotics.
	Response by Registered Person(s) Detailing the Actions Taken: It was highlighted during the meeting that antibiotic therapy was extremely important and if there was any deviation in administration the GP should be notified and this should be recorded.
Recommendation 3 **Ref:** Standard 30 **Stated:** First time **To be Completed by:** 20 November 2015	The registered person should ensure that detailed care plans for the management of distressed reactions and pain are in place for when necessary.
	Response by Registered Person(s) Detailing the Actions Taken: A review of all relevant careplans have been carried out by the Manager and the appropriate documentation is now in place.

Registered Manager Completing QIP	P. Kennedy	**Date Completed**	6/11/15.
Registered Person Approving QIP	C J WALSH	**Date Approved**	16/11/15.
RQIA Inspector Assessing Response		**Date Approved**	

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

The Regulation and Quality Improvement Authority

RQIA Inspector Assessing Response	Helen Daly	**Date Approved**	25/11/15