Unannounced Medicines Management Inspection Report
20 February 2017

The Pines

Type of service: Residential Care Home
Address: 23 Upper Lisburn Road, Belfast, BT10 0GW
Tel No: 028 9060 2343
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of The Pines took place on 20 February 2017 from 10.00 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.

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. There were largely satisfactory systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. However, the registered provider should ensure that the maximum and minimum temperatures are recorded daily. A 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. The registered provider should ensure that specific dosage directions are recorded for medicines which are prescribed on a "when required" basis for the management of distressed reactions. A recommendation 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 for 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 share learning from any medicine related incidents and medicine audit activity. There were no areas for 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	0	2

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Rhonda Spence, 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 15 October 2016.

2.0 Service details

Registered organisation/registered person: The Pines/ Mr Kevin McKinney	**Registered manager:** See below
Person in charge of the home at the time of inspection: Mrs Christine Jennings, Deputy Manager, then Mrs Rhonda Spence, Manager	**Date manager registered:** Mrs Rhonda Spence (Registration pending)
Categories of care: RC-PH, RC-DE, RC-I	**Number of registered places:** 31

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, the manager and the deputy manager.

Fifteen questionnaires were issued to residents, relatives/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:

- 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 15 October 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 the next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 7 January 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The responsible person must ensure that written confirmation of current medicine regimes is obtained from a health or social care professional for new admissions to the home.	**Met**
	Action taken as confirmed during the inspection: Confirmation of the medicine regimes is routinely obtained either in the form of a discharge letter from the hospital or a fax from the resident's general practitioner. This was observed during the inspection.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must ensure that two members of staff verify and sign all updates on the personal medication records and hand-written entries on the medication administration records.	**Met**
	Action taken as confirmed during the inspection: It was observed during the inspection that two members of staff update these records.	

Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must ensure that records for the prescribing and administration of bisphosphonate medicines accurately reflect practice.	**Met**
	Action taken as confirmed during the inspection: It was observed that these medicines are administered at 07.00 and are stored separately from the other morning medicines. The correct time of administration was recorded on the personal medication records.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 30 **Stated:** Second time	The management of warfarin should be reviewed and revised.	**Met**
	Action taken as confirmed during the inspection: None of the residents were prescribed warfarin at the time of this inspection, however, the manager explained how it would be managed and provided samples of the documentation that would be completed. These arrangements were satisfactory.	
Recommendation 2 **Ref**: Standard 31 **Stated:** First time	The registered manager should ensure that obsolete personal medication records are cancelled and archived	**Met**
	Action taken as confirmed during the inspection: Obsolete records had been cancelled and archived.	
Recommendation 3 **Ref**: Standard 31 **Stated:** first time	The registered manager should ensure that where medicines are prescribed at variable dose i.e. one or two capsules, the actual dose administered is recorded.	**Met**
	Action taken as confirmed during the inspection: This had been documented on the records observed during the inspection.	

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 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.

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.

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.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Medicine refrigerators were checked at regular intervals, however only the current temperature of the refrigerator was recorded. The maximum and minimum temperatures should be recorded and this was discussed with the manager. A recommendation was made.

Areas for improvement

The registered provider should ensure that the maximum and minimum refrigerator temperatures are recorded daily. 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 reason for and the outcome of administration were recorded. A care plan was maintained. 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 specific dosage instructions had not been recorded

on the personal medication record. The dosage instruction should indicate the maximum number of tablets that can be administered over 24 hours and/or the minimum dosage interval to be observed. This was discussed with the manager and a recommendation was made.

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.

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 separate records for the administration of food supplements and analgesics.

Practices for the management of medicines were audited by the staff and management. This included running stock balances for some medicines not contained in the blister packs.

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

Areas for improvement

The registered provider should ensure that specific dosage directions are recorded for medicines which are prescribed on a "when required" basis for the management of distressed reactions. A recommendation was made.

Number of requirements	0	**Number of recommendations**	1

4.5 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 were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

The residents spoken to said that they had no concerns in relation to the management of their medicines.

Questionnaires were completed by four residents. All of the responses in the questionnaires indicated that they were "satisfied" with the management of their medicines.

Three relatives completed the questionnaire. The majority of the responses were positive and raised no concerns about medicines management in the home. One response indicated that there may be a shortage of staff. This was discussed with the manager and it was confirmed that the staffing levels were appropriate.

One relative commented that the "Manager is always available and I am always impressed with how quickly they act if it is necessary to contact the doctor or if there is any infection…I am always informed if there is any change in XXX's treatment".

Three members of staff completed the questionnaire. No issues were raised.

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.

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 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 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 Mrs Rhonda Spence, 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 the web portal 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:** 22 March 2017	The registered provider should ensure that the maximum and minimum refrigerator temperatures are recorded daily. A recommendation was made. **Response by registered provider detailing the actions taken:** The maximum and minimum temperatures for the refrigerator are now recorded daily when checking the refrigerator temperature.
Recommendation 2 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 22 March 2017	The registered provider should ensure that specific dosage directions are recorded for medicines which are prescribed on a “when required” basis for the management of distressed reactions. **Response by registered provider detailing the actions taken:** Specific dosage directions have been recorded on the medication prescription sheets.

Please ensure this document is completed in full and returned to the RQIA web portal

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