Unannounced Medicines Management Inspection Report
31 August 2017

Redlands

Type of service: Residential Care Home
Address: 20 Adelaide Park, Belfast, BT9 6FX
Tel No: 028 9066 1526
Inspector: Helen Daly

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

3.0 Service details

Organisation/Registered Provider: Whiteabbey Proprietors Ltd **Responsible Individual:** Mr Mark John Uprichard	**Registered Manager:** Ms Irene Caroline Best
Person in charge at the time of inspection: Ms Irene Best (until 14.00) Mrs Julie Davidson (14.00 – 15.10) (Person in Charge)	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) I – old age not falling within any other category DE – dementia	**Number of registered places:** 17

4.0 Inspection summary

An unannounced inspection took place on 31 August 2017 from 10.15 to 15.10.

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 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 staff interactions with residents.

Areas requiring improvement were identified in relation to record keeping, the management of medication changes, the home's auditing system and the management of distressed reactions.

One resident said that they were "very happy in the home, staff are kind and the food is great".

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	3	1

Details of the Quality Improvement Plan (QIP) were discussed with Ms Irene Best, Registered Manager, during the inspection and with Mrs Julie Davidson, Person in Charge, at the end of the inspection. 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 16 February 2017. Other than the action 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 incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection

During the inspection the inspector met with several residents, the cook, two care assistants and the registered manager.

A total of 15 questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA.

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
- medicine audits
- care plans
- medicines storage temperatures

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 16 February 2017

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 care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 26 January 2015

There were no areas for improvement made as a result of the last medicines management inspection.

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.

The registered manager advised that medicines were managed by staff who have been trained and deemed competent to do so. Training was provided by the community pharmacist every two years. Competencies were assessed annually. The impact of training was monitored through observation of practice and the audit process. Update medicines management training was planned for October 2017. It was suggested that the training should be tailored to include the issues identified at this inspection.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Antibiotics and newly prescribed medicines had been received into the home without delay. Prescriptions were not received into the home prior to being forwarded to the community pharmacy; photocopies were provided to ensure that staff had access to the current prescription details.

There were unsatisfactory arrangements in place to manage changes to prescribed medicines. These included newly prescribed medicines and antibiotics. Several changes had not been recorded on the personal medication records. They had been recorded on the medication administration records only. There was poor correlation between the personal medication records and the medication administration records. A clear and concise procedure for recording medication changes and receiving medicines into the home was displayed on the wall of the treatment room. Discussion with staff on duty indicated that they were aware of the correct procedures but they were not being followed by all staff and this was not being identified by the home's auditing system. An area for improvement was identified.

In relation to safeguarding, the registered manager advised that she was aware that there were new procedures but that she had not yet attended training.

There had been no recent admissions. The registered manager confirmed that 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. She advised that written confirmation of currently prescribed medicines would be requested from the prescriber.

There were no controlled drugs which required entry in a controlled drugs record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Two members of staff were involved in the administration of these medicines.

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

A new treatment room was in use. The registered manager was unsure if the documentation had been submitted to RQIA. This was referred to the estates inspector on 1 September 2017. Medicines were stored safely and securely and in accordance with the manufacturer's instructions. The room temperature and refrigerator temperature were checked daily. A small number of out of date medicines were removed for disposal. It was agreed that date checking would be included in the auditing process.

Areas of good practice

There were examples of good practice in relation to the storage of medicines.

Areas for improvement

The registered person shall ensure that there are safe systems in place for managing medication changes.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Most medicines were supplied in the blister pack system. The majority of medicines examined had been administered in accordance with the prescriber's instructions. However, for one resident it was unclear if their creams had been administered as prescribed due to the poor standard of record keeping. This finding was discussed in detail with the registered manager and care assistants on duty who confirmed that the resident's skin condition was improving and that the correct cream was currently being administered. It was agreed that the records would be clearly recorded from the date of the inspection onwards.

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 or twice 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. Care plans were not in place and the reason for and the outcome of each administration was not being recorded. An area for improvement was identified.

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. The registered manager advised that the majority of residents could verbalise their pain. Care plans were maintained.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Care plans and speech and language assessment reports were in place. Administration was being recorded on the medication administration records.

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.

Significant improvements are necessary in the standard of maintenance of the personal medication records which were not up to date. Some recently prescribed medicines had not been recorded and some discontinued medicines had not been cancelled. The registered manager and care assistants were reminded that:

- personal medication must be up to date and reflect the prescribers most recent directions
- two members of trained staff should sign and verify the personal medication records at the time of writing and at each update
- the date of writing should be recorded
- the date of prescribing of each medicine should be recorded
- the strength and dose of each medicine should be clearly recorded

An area for improvement was identified.

Records of receipt and administration had been maintained in a mostly satisfactory manner. A small number of discrepancies were discussed for clearer recording, including the management of one resident's creams, as detailed above.

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

Areas of good practice

There were examples of good practice in relation to the management of pain.

Areas for improvement

The registered person shall ensure that personal medication records are up to date and the areas identified for improvement addressed.

The registered person shall review that management of distressed reactions to ensure that care plans are in place. The reason for and outcome of each administration should be recorded.

	Regulations	Standards
Total number of areas for improvement	1	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.

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

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.

Of the questionnaires that were issued, one was returned from a resident and three were returned from staff. The responses indicated that they were very satisfied / satisfied with all aspects of the care in relation to the management of medicines.

We spoke with several residents who appeared content in the home. Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Areas of good practice

Staff listened to residents and relatives 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.

The registered manager advised that written policies and procedures for the management of medicines were in place. These were not examined at the inspection.

Practices for the management of medicines were audited throughout the month by the staff and management. This included a running stock balance for medicines not supplied in the blister packs and inhaled medicines. In addition a monthly audit was completed. A review of the monthly audits indicated that satisfactory outcomes had been achieved. This did not reflect the findings of this inspection indicating that the home's audit system is not robust. The audits should focus on record keeping, the management of complex skin regimens and date checking. To ensure that the Quality Improvement Plan is fully addressed and the improvement sustained, it was recommended that the QIP should be regularly reviewed as part of the auditing process. An area for improvement was identified.

No incidents involving medicines had been reported to RQIA since the last medicines management inspection. Due to the lack of a robust auditing system, incidents may not be identified; this was discussed with staff on duty. The registered manager was reminded that in line with the regional safeguarding procedures medicine incidents may need to be reported to the safeguarding team.

Following discussion with the registered 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 at handovers.

Areas of good practice

There were clearly defined roles and responsibilities for staff.

Areas for improvement

The registered person shall implement a robust auditing system to ensure that any shortfalls in relation to medicines management are identified and improvements are sustained.

	Regulations	Standards
Total number of areas for improvement	1	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 Ms Irene Best, Registered Manager, and with Mrs Julie Davidson, Person in Charge, at the end of the inspection. 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 to pharmacists@rqia.org.uk for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 1 October 2017	The registered person shall ensure that there are safe systems in place for managing medication changes.
	Response by registered person detailing the actions taken: Procedures in place for staff when receiving new prescribed medication. When recording in the incoming book they must also sign to indicate they have updated the kardex and MAR This will be monitored by management.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 1 October 2017	The registered person shall ensure that personal medication records are up to date and the areas identified for improvement addressed.
	Response by registered person detailing the actions taken: Main kardex and MAR for each individual updated to reflect current medication, strength and dose
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 1 October 2017	The registered person shall implement a robust auditing system to ensure that any shortfalls in relation to medicines management are identified and improvements are sustained.
	Response by registered person detailing the actions taken: The audit process has been improved and is supervised by the home manager.
Action required to ensure compliance the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 8 **Stated:** First time **To be completed by:** 1 October 2017	The registered person shall review that management of distressed reactions to ensure that care plans are in place. The reason for and outcome of each administration should be recorded.
	Response by registered person detailing the actions taken: Care plans in place to enclude procedure for admininstration of medication for distressed reaction

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