Unannounced Medicines Management Inspection Report
4 January 2017

Sir Samuel Kelly Memorial Eventide Home

Type of Service: Residential Care Home
Address: 39 Bangor Road, Holywood, BT18 0NE
Tel no: 028 9042 2293
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Sir Samuel Kelly Memorial Eventide Home took place on 4 January 2017 from 10.20 to 15.20.

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 some areas of the management of medicines supported the delivery of safe care and positive outcomes for residents. Staff administering medicines were trained and competent. Areas for improvement were identified in relation to stock control of medicines and the management of controlled drugs. To ensure that the management of medicines is in compliance with legislative requirements and standards one requirement and one recommendation have been made.

Is care effective?

Some areas of the management of medicines supported the delivery of effective care. The audit outcomes indicated that residents were receiving their medicines as prescribed. Care plans in relation to pain management and swallowing difficulty were in place. The majority of medicines records had been maintained in the necessary manner. However, two areas for improvement were identified in relation to record keeping for delegated medicine tasks and the administration of medicines. One requirement and one recommendation have been 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?

Some areas of the service were 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. However, the management of incidents and governance arrangements for medicines require review. Two requirements and one recommendation were made. One requirement was stated for a second time.

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	4	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Linda Hook, Registered 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 premises 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 December 2016.

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: The Salvation Army/Mrs Elaine Cobb	**Registered manager:** Mrs Linda Hook
Person in charge of the home at the time of inspection: Mrs Linda Hook	**Date manager registered:** 30 September 2008
Categories of care: RC-MP, RC-TI, RC-I, RC-DE	**Number of registered places:** 40

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the incidents register – it was ascertained that no medicine related incidents had been reported to RQIA since the last medicines management inspection

We met with three residents, one resident's relative, one team leader and the registered manager.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector.

Twenty-five questionnaires were issued to residents, relatives/resident representatives and staff, with a request that these were returned within one week 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 15 December 2016

The most recent inspection of the home was an announced premises inspection. The report is pending. Any areas for improvement will be followed up by the estates inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 25 June 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13(4) **Stated:** Second time	The MARs sheets must be fully and accurately completed. **Action taken as confirmed during the inspection**: With the exception of one medicine, the MARs sheets were well maintained.	**Met**
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered manager must closely audit those medicines highlighted as having audit discrepancies as part of the routine audit process. **Action taken as confirmed during the inspection**: This requirement was made with reference to three medicines. There was evidence of regular auditing of one of the medicines, one of the medicines was no longer prescribed and there was no evidence of auditing of the third medicine, which was an inhaled medicine. An audit discrepancy was noted for the inhaled medicine. As written this requirement has been partially met, and as areas for improvement were identified in other medicines, as detailed in the report, this requirement has been subsumed into a requirement regarding the audit process.	**Partially Met**

Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must ensure that staff are aware of what constitutes a reportable incident and that they are all appropriately reported. **Action taken as confirmed during the inspection**: This requirement was made in relation to reporting medicines which were out of stock. At this inspection, it was noted that one analgesic medicine had been out of stock for five days and one issue in relation to a resident with swallowing difficulty was highlighted. These incidents had not been reported to RQIA. This requirement has not been met and is stated for a second time.	**Not Met**
Requirement 4 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must ensure that personal medication records are up to date at all times. **Action taken as confirmed during the inspection**: The sample of personal medication records examined was well maintained.	**Met**
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 31 **Stated:** Second time	Updates to the personal medication record and hand-written entries on the MARs sheets should be verified and signed by two members of staff. **Action taken as confirmed during the inspection**: There was evidence that two staff usually record new medicine details on personal medication records and medication administration records.	**Met**

Recommendation 2 **Ref:** Standard 30 **Stated:** First time	The registered manager should review the management of 'when required' medicines for the treatment of distressed reactions to ensure that all of the appropriate records are maintained.	**Met**
	Action taken as confirmed during the inspection: Of the residents files examined, a small number of residents were prescribed these medicines. A care plan was in place for the resident that required occasional administration. The reason for the administration was recorded. For residents who were prescribed these medicines, but never required them, a care plan was not in place. This was further discussed and the registered manager advised that these care plans would be put in place. As written this recommendation has been partially met, however, due to the assurances provided by the registered manager, it has been assessed as met.	

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. The registered manager advised that a programme of training was in place. This was provided by a representative from the community pharmacy and also by the completion on e-learning and medicine work books. A sample of topics in relation to medicines was provided; they included dysphagia, dementia, medicines management, skincare, nutrition and pain management.

The systems in place to manage the ordering of prescribed medicines must be reviewed. It was noted that one analgesic medicine had been out of stock for five days. This had not been followed up in a timely manner, and the resident's pain control was discussed with staff and the registered manager. Staff confirmed that the medicine had been requested from the prescriber. The stock control of medicines had also been raised at the last medicines management inspection. A requirement was made. See Sections 4.2 and Section 4.6.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were usually 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. An apparent discrepancy in a stock balance was observed. It was later clarified that the controlled drug had been administered, but had not been recorded. This highlighted that there were no checks on controlled drugs which require safe custody at the end of each shift and was also discussed in relation to checking systems at the time of administration. The storage arrangements for the controlled drug key should be reviewed to ensure this is only accessible by the person on duty who is in charge of medicines. A recommendation was made.

Appropriate arrangements were in place for administering medicines in disguised form.

Since the last medicines management inspection, a new medicine storage system had been introduced. Medicines were stored safely and securely in the residents' bedrooms and were stored in in accordance with the manufacturer's instructions. A medicine refrigerator was also in use; temperatures were recorded on a daily basis. Whilst it was noted that medicines with a limited shelf life once opened, were marked with the date of opening and most were in date, one eye preparation had expired and was removed from stock for disposal. It was advised that these preparations should be included in the audit process. See also Section 4.6.

Discontinued or expired medicines were disposed of appropriately.

Areas for improvement

The necessary arrangements must be made to ensure that all medicines are available for administration. A requirement was made.

The management of controlled drugs should be reviewed in relation to storage of the controlled drug key and ensuring that stocks are checked at each shift change. A recommendation was made.

Number of requirements	1	Number of recommendations	1

4.4 Is care effective?

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. One discrepancy in an inhaled medicine was noted and discussed with staff. It was agreed that close monitoring would be undertaken and a daily stock balance recorded.

There was evidence that the majority of time critical medicines had been administered at the correct time. However, there was no evidence that bisphosphonate medicines were administered at separate times from food or other medicines, in accordance with the manufacturer's instructions. A recommendation was made.

There were arrangements in place to alert staff of when doses of twice weekly and 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. These medicines were rarely required to be administered. The reason for the administration was recorded. A care plan was maintained for the resident who required occasional administration. As detailed in Section 4.2, it was agreed that a care plan would be put in place for all residents prescribed these medicines.

With the exception of the out of stock analgesic medicine, 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 some of the residents could verbalise any pain, and a pain assessment tool was used as needed for those unable to verbally express pain. A sample of pain assessments were provided at the inspection.
The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record, but did not include details of the fluid consistency. It was agreed that this would be recorded after the inspection. A care plan and speech and language assessment report was in place.

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.

Most of the medicine records were well maintained and facilitated the audit process. For one eye preparation there were no records of administration in the current medicine cycle. Staff assured that this medicine was being administered. The registered manager advised that this was an oversight and confirmed by telephone on 9 January 2017 that this had been addressed immediately after the inspection. In relation to delegated medicines tasks, there was no system in place to enable care staff to record the administration of external preparations and thickening agents. A record of all administered medicines must be maintained. A requirement was made.

Following discussion with the registered manager and staff, and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to issues or concerns regarding medicines management.

Areas for improvement

The management of bisphosphonate medicines should be reviewed to ensure that all staff are aware of the manufacturer's instructions and the time of administration is accurately recorded on the MAR sheets. A recommendation was made.

A system must be developed to ensure that a record of all administered medicines is maintained. A requirement was made.

Number of requirements	1	Number of recommendations	1

4.5 Is care compassionate?

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

The registered manager advised the changes to the medicine system had been introduced to enhance the procedures for the safe administration of medicines and that it allowed medicines to be administered discreetly in each resident's room and in accordance with the residents preferences, e.g. it was noted that some medicines were administered later as the resident wished to sleep for longer periods in the morning.

Residents advised that they had no concerns regarding the management of their medicines. They confirmed that their requests for medicines were adhered to in a timely manner, e.g. pain relief. They were complimentary about the staff.

The relative spoken advised that they had no concerns regarding the care of the resident, however, raised a query regarding one medicine. This was discussed with the registered manager with the relative's consent.
Residents who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As part of the inspection process, questionnaires were provided for residents, relatives/residents' representatives and staff. No questionnaires had been returned at the time of issuing the report.

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. These were reviewed every three years and were due for review this year. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

The management of incidents was reviewed. Staff confirmed that they knew how to identify and report incidents. There had been no medicine related incidents reported since the last medicines management inspection. However, as stated earlier, a medicine had been out of stock in the last week. This had not been reported. It was also found that there had been an incident relating to a resident with swallowing difficulty. Although staff advised of the action taken and the learning from the incident, this had not been reported. This was shared with the care inspector for this home. The requirement regarding incident reporting has been stated for a second time.

A review of the audit records indicated that satisfactory outcomes had been achieved. A weekly audit was completed on most solid dosage medicines and good outcomes were achieved. Staff advised of the systems in place to manage any discrepancies. However, the audits did not include a review of other formulation of medicines and issues regarding these medicines were observed at the inspection. Due to the inspection findings, the need to ensure that all formulations of medicines are included in the audit process was reiterated, i.e. eye drops, inhalers, external preparation and thickening agents. A requirement was made.

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.

Not all of the requirements made at the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement sustained, it was recommended that the QIP should be regularly reviewed as part of the quality improvement process.

Staff confirmed that any concerns in relation to medicines management were raised with management.

Areas for improvement

Robust arrangements must be put in place to report incidents. A requirement was stated for a second time.

The audit process for medicines management must be further developed to ensure that it covers all aspects of medicines management. A requirement was made.

The QIP should be used as part of the auditing process for medicines. A recommendation was made.

Number of requirements	2	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Linda Hook, Registered 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 **RQIA's office** 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.

Judith Taylor

Quality Improvement Plan

Statutory requirements

Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time **To be completed by:** 4 February 2017	The registered manager must ensure that staff are aware of what constitutes a reportable incident and that they are all appropriately reported. **Response by registered provider detailing the actions taken:** Staff are now aware of what constitutes as a reportable incident though staff meeting.
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 4 February 2017	The registered provider must make the necessary arrangements to ensure that all medicines are available for administration as prescribed. **Response by registered provider detailing the actions taken:** Medication was received that evening from BOOTS. Medication had been requested but interim had not been put on prescription. Medication was put in with monthly order Medication for PRN(as required) medication and eyedrops where received that evening.
Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 4 February 2017	The registered provider must ensure that a record of all administered medicines is maintained. **Response by registered provider detailing the actions taken:** Thickner consistency for residents has been shown to all care staff in home. Information and how to mix is now highlighted in careplans and Main prescription sheets. This also covers all creams & shampoo's eyedrop & inhalers ensuring that a record of all administered medicines are Maintained.

Requirement 4 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 4 February 2017	The registered provider must develop the audit process to ensure this covers all aspects of medicines management.
	Response by registered provider detailing the actions taken: These are now in place & cover cream and eye drop & inhalers etc.
Recommendations	
Recommendation 1 **Ref:** Standard 32 **Stated:** First time **To be completed by:** 4 February 2017	The registered provider should review the management of controlled drugs to ensure robust arrangements are in place.
	Response by registered provider detailing the actions taken: Handover CD Book for medications now in place.
Recommendation 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 4 February 2017	The registered provider should review the management of bisphosphonate medicines.
	Response by registered provider detailing the actions taken: further training was given to staff in regard to the use of bisphosphonate medication Staff ensure that it is given with water only on other medication given later.

RQIA ID: 1653/Inspection ID: IN025154

Recommendation 3 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 4 February 2017	The registered provider should include the QIP in the auditing process. **Response by registered provider detailing the actions taken:** This is now in place

The Regulation and Quality Improvement Authority

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