Unannounced Medicines Management Inspection Report
8 January 2019

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: Frances Gault

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 that provides care for up to 40 residents as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: The Salvation Army **Responsible Individual:** Mrs Elaine Cobb	**Registered Manager:** Mrs Sharon Boyd
Person in charge at the time of inspection: Ms Sharron Cushley, Head of Care	**Date manager registered:** 31 August 2018
Categories of care: Residential Care Home (RC): I – Old age not falling within any other category DE – Dementia MP – Mental disorder excluding learning disability or dementia TI – Terminally ill	**Number of registered places:** 40 comprising: RC-I – 12 residents RC-DE – 24 residents RC-MP – 2 residents RC-TI – 2 residents

4.0 Inspection summary

An unannounced inspection took place on 8 January 2019 from 10.30 to 14.40.

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 during and 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 management of personal medication records and the administration of most medicines.

Areas requiring improvement were identified in relation to the administration records for some medicines, the admission procedures, the management of controlled drugs and audit.

Residents said that the food was lovely and the staff “couldn’t be better”.

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	2	3

The total number of areas for improvement includes one in relation to the regulations which has been stated for a second time and two in relation to the standards which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Ms Sharron Cushley, Head of Care, as part of the inspection process. Mrs Sharon Boyd, Registered Manager was advised of the findings of the inspection during a telephone call on 21 January 2019. 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 18 June 2018. Other than those actions 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 six residents, three staff and one resident's relative.

A total of 10 questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

We left 'Have we missed you?' cards in the home to inform residents and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- controlled drug record book
- medicine audits
- care plans
- medicines disposed of

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 18 June 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was 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 4 January 2017

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The registered person must ensure that staff are aware of what constitutes a reportable incident and that they are all appropriately reported.	**Met**
	Action taken as confirmed during the inspection: No incidents had been reported since the last medicine management inspection. Staff were aware of what should be reported. This was discussed with the person in charge in light of one of the medicine audit findings and she was aware of the process to be followed. Given this assurance this area for improvement was assessed as met.	
Area for improvement 2 **Ref**: Regulation 13(4**)** **Stated:** First time	The registered provider must make the necessary arrangements to ensure that all medicines are available for administration as prescribed.	**Met**

	Action taken as confirmed during the inspection: The sample of medicines reviewed evidenced that all were available for administration.	
Area for improvement 3 **Ref**: Regulation 13(4) **Stated:** First time	The registered provider must ensure that a record of all administered medicines is maintained.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement had been made in relation to the recording of the administration of external preparation and thickening agents. Care staff and management advised that no records were maintained of the administration of thickening agents. This was discussed in detail with the management after the inspection. This area for improvement was stated for the second time.	
Area for improvement 4 **Ref**: Regulation 13(4) **Stated:** First time	The registered provider must develop the audit process to ensure this covers all aspects of medicines management.	**Met**
	Action taken as confirmed during the inspection: There is a weekly, monthly and six monthly audit programme in place which covers all aspects the management of medicines.	
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 32 **Stated:** First time	The registered person should review the management of controlled drugs to ensure that robust arrangements are in place.	**Partially met**
	Action taken as confirmed during the inspection: Management advised that the controlled drug hand over book had been put in place. They had then stopped using it but had recently reinstated its use. The purpose of the record was discussed. It is to record the handover of	

	responsibility for controlled drugs from one member of staff to another. The current safe keeping arrangements for the key to the controlled drugs were discussed. Management were advised that this should be kept on the person of the member of staff in charge of the controlled drugs. If the controlled drug key is not directly handed over to another member of staff a risk assessment of the storage arrangement should be in place. The arrangements for the involvement of care staff in the checking process were discussed (see Section 6.4). This area for improvement was stated for the second time.	
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time	The registered provider should review the management of bisphosphonate medicines.	**Not met**
	Action taken as confirmed during the inspection: The medicine administration records did not show that these were administered before other medicines although staff did advise that this was the practice. This area for improvement was stated for the second time.	
Area for improvement 3 **Ref**: Standard 30 **Stated:** First time	The registered provider should include the QIP in the auditing process.	**Not met**
	Action taken as confirmed during the inspection: Management advised that this was used during the audit process. However, the outcome of this inspection and the areas for improvement having to be restated would indicate that this process is not embedded into routine practice. This area for improvement was stated for the second time.	

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.

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for all care staff who had responsibility for the administration of medicines. 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 June 2018. See also controlled drugs section below.

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.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

The procedures in place to ensure the safe management of medicines during a resident's admission to the home were discussed. It was acknowledged that satisfactory arrangements were in place for residents admitted from hospital. However, confirmation of the currently prescribed medicines was not received from the general practitioner when a resident was admitted from their own home. Confirmation was only obtained from the medicine labels and the family. In a recent admission the resident had been prescribed a high risk medicine, which required close monitoring and this had not been followed up for a number of weeks. An area for improvement was identified.

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.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Where care staff are involved in checking the quantities of controlled drugs in the home training should be provided to ensure that they understand their role (see Section 6.2). The management of controlled drugs still requires improvement and the area for improvement in relation to this was stated for a second time (see Section 6.2).

The arrangements in place for the management of residents prescribed insulin were discussed. This was the responsibility of the community nursing team. A care plan was in place in relation to staff involvement in the management of the condition. It was agreed that the dose of insulin would be included on the personal medication record and the entry highlighted to identify that the administration was the responsibility of the community nursing team.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely in each resident's bedroom. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The medicine refrigerator was checked at regular intervals.

Areas of good practice

There were some examples of good practice in relation to staff training and competency assessments.

Areas for improvement

The area for improvement in relation to the management of controlled drugs was stated for a second time. A new area for improvement was identified in relation to the admission procedures.

	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.

The majority of the sample of medicines examined had been administered in accordance with the prescriber's instructions. There was no evidence that bisphosphonate medicines had been administered at a different time from other medicines as required (see Section 6.2). The area for improvement identified at the last inspection was stated for a second time.

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, and a pain assessment tool was used as needed.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record. Staff confirmed that the administration was not recorded. This was discussed with management and the area for improvement in relation to the records of the administration of medicines stated for a second time. See Section 6.2

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.

The majority of medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the involvement of two staff in writing the personal medication records.

One resident had recently been prescribed a medicine where the dose increased over four weeks. The record keeping in relation to this was clear for staff to understand and administer the correct dose.

Staff were advised that when the actual dose of the medicine (e.g paracetamol) administered was recorded on the administration records, the entry should be legible. It was agreed that this would be raised with staff.

Following discussion with the management and staff, it was evident that when applicable, other healthcare professionals are contacted in response to the healthcare needs of the residents.

Areas of good practice

There were examples of good practice in relation to the standard of the personal medication records and the administration of most medicines.

Areas for improvement

The areas for improvement in relation to the administration records for bisphosphonates and thickening agents were stated for a second time.

No new areas for improvement were identified.

	Regulations	Standards
Total number of areas for improvement	0	0

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. Risk assessments were in place and staff agreed to record "self-administered" on the personal medication records. Management were able to advise how they enabled residents to administer their prescribed medicines.

As residents' medicines are stored in their bedrooms, staff are able to administer them, giving each resident time and privacy.

We spoke to a small number of residents in their bedrooms prior to examining their medicines. All expressed satisfaction with their care. Comments included:

- "(staff) couldn't be better."
- "(food) plenty of it."
- "The home baking is lovely especially the banana cake."
- "Scones are lovely."
- "I only take paracetamol when I need to as I don't like taking too many."

We also met with one relative who commented that “the care is fantastic”

During the inspection several residents were taking part in a service of worship.

Of the questionnaires that were issued, none were returned from residents and their representatives within the specified time frame (two weeks).

Any comments from residents and their representatives in questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Areas of good practice

Staff listened to residents and relatives and took account of their views. The medicine administration procedure is resident focused.

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.

Written policies and procedures for the management of medicines were in place. These were not examined during this inspection.

The governance arrangements for medicines management were examined. It was acknowledged that there were auditing systems in place and these were carried out by staff and management and there was support from the community pharmacist. We reviewed a sample of auditing records and largely satisfactory outcomes had been achieved. However, the inspection findings indicate that the internal auditing processes have not been effective in identifying issues; this has resulted in areas for improvement being stated for a second time, in the domains of safe and effective care. We had discussed the benefit of including the QIP in the audit processes to ensure sustained improvement and this area for improvement has also been stated for a second time.

Following discussion with the care staff on duty, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. However, during discussion with management, an area for improvement was identified in relation to the involvement of care staff in checking controlled drugs (see Section 6.2 and 6.4).

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

No online questionnaires were completed by staff with the specified time frame (two weeks).

Areas for improvement

The area for improvement previously made that the QIP should be regularly reviewed as part of the quality improvement process has been stated for a second time.

No new areas for improvement were identified.

	Regulations	Standards
Total number of areas for improvement	0	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 Sharron Cushley, Head of Care, during the inspection and Mrs Sharon Boyd, Registered Manager, by telephone after the inspection as part of the inspection process. 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 via the Web Portal for assessment by the inspector.

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:** Second time **To be completed by:** 8 February 2019	The registered provider must ensure that a record of all administered medicines is maintained. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken: Staff carrying out the audits have been advised to use the QIP during this process as a reminder of areas to be considered from the Medication Inspection.
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 8 February 2019	The registered person shall ensure that written confirmation of the current medicine regime is obtained from the general practitioner when residents are admitted from their own home. Ref: 6.4
	Response by registered person detailing the actions taken: Staff responsible for the admission of a new resident into the home are now aware the this requirement to request a list of current medications from the GP. This will be adhered to and monitored through admission process audits and at weekly management meetings where all new admissions are discussed.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 32 **Stated:** Second time **To be completed by:** 8 February 2019	The registered person should review the management of controlled drugs to ensure that robust arrangements are in place. Ref: 6.2 and 6.3
	Response by registered person detailing the actions taken: Staff responsible for the administration of medicines within the home have been advised that the CD key must be held on the person for that shift. This handover of the key must be recorded and signed by two staff at the point of handover. Overnight when there is not a team leader with this resposnibility on duty the key is placed in a locked cupboard in the home managers office. This is recorded and signed by two staff. There is a risk assessment and procedure now in place which cleary outlines the carrying and storage of the CD key.At each handover throughout the day the controlled drugs are counted by the team leader and witnessed by another team leader or other member of staff.normally an acting team leader. These staff members are trained in the administration of medicines within the home.

Area for improvement 2 **Ref**: Standard 30 **Stated:** Second time **To be completed by:** 8 February 2019	The registered person should review the management of bisphosphonate medicines. Ref: 6.2 and 6.5
	Response by registered person detailing the actions taken: A review has taken place of the administration of Bisphosphonate medicines. All staff with the responsibility for the administration of medicines have been reminded of the importance of adhering strictly to the time of administration of this medicine. This will be monitored through the auditing process within the home and discussed and recorded at weekly management meetings.
Area for improvement 3 **Ref**: Standard 30 **Stated:** Second time **To be completed by:** 8 February 2019	The registered person should include the QIP in the auditing process. Ref: 6.2and 6.7
	Response by registered person detailing the actions taken: All staff carrying out the medication audits within the home have been advised that it is essential to use the QIP during this process in order to consider and monitor effectively all areas highlighted for improvement during the Medication Inspection. This is now in place, The QIP template will be placed with the aiditing template to remind staff this is the new process..

Please ensure this document is completed in full and returned via the Web Portal

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