Unannounced Medicines Management Inspection Report
4 May 2016

Summerhill

31 Upper Gransha Road, Bangor, BT19 7QF
Tel No: 028 9146 1185
Inspector: Paul Nixon

1.0 Summary

An unannounced inspection of Summerhill took place on 4 May 2016 from 09:35 to 12:30.

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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern though two areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

Is care safe?

No requirements or recommendations have been made.

Is care effective?

Two recommendations have been made.

Is care compassionate?

No requirements or recommendations have been made.

Is the service well led?

No requirements or recommendations have been made.

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 QIP within this report were discussed with Mr Hugh Warden, 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 care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the inspection on 15 October 2015.

2.0 Service details

Registered organisation/registered person: Summerhill Residential Home Ltd / Mr Hugh Frederick Warden	**Registered manager:** Mr Hugh Frederick Warden
Person in charge of the home at the time of inspection: Mr Hugh Frederick Warden	**Date manager registered:** 1 April 2005
Categories of care: RC-I ,RC-PH (E), RC-DE, RC-SI	**Number of registered places:** 23

3.0 Methods/processes

Prior to inspection the following records were analysed:

- 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.

Prior to the inspection, it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with three residents, the registered manager and the deputy matron.

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 October 2015

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The full dosage instructions for the administration of diazepam, prescribed for administration on a when required basis to one resident, must be specified on the personal medication record and medication administration record.	**Met**
	Action taken as confirmed during the inspection: The full dosage instructions for the administration of diazepam, prescribed for administration on a when required basis for two residents, was specified on the personal medication records and medication administration records.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	All medication requiring cold storage must be securely stored.	**Met**
	Action taken as confirmed during the inspection: All medication requiring cold storage was securely stored in the locked medicines refrigerator.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 31 **Stated:** Second time	Two members of staff should sign all hand-written updates on the personal medication records and medication administration records.	**Met**
	Action taken as confirmed during the inspection: Two members of staff had signed hand-written updates on the personal medication records and medication administration records.	
Recommendation 2 **Ref**: Standard 30 **Stated:** First time	Review the management of warfarin dosage changes. As part of best practice staff should maintain a daily stock balance for warfarin and two members of staff should be involved when transcribing warfarin dosage regimes.	**Met**
	Action taken as confirmed during the inspection: The management of warfarin dosage changes had been reviewed. Daily stock balances had been maintained and two members of staff had transcribed the warfarin dosage regimes.	
Recommendation 3 **Ref**: Standard 30 **Stated:** First time	Written confirmation of current medication regimes should be requested from the prescriber for all new admissions.	**Met**
	Action taken as confirmed during the inspection: Two recently admitted residents' records were examined. In each instance, written confirmation of the current medication regime had been obtained from the prescriber.	
Recommendation 4 **Ref**: Standard 30 **Stated:** First time	Prescriptions should initially be received by the home for checking before being submitted to the pharmacy.	**Met**
	Action taken as confirmed during the inspection: The registered manager and staff confirmed that prescriptions were initially received by the home for checking before being submitted to the pharmacy.	

Recommendation 5 **Ref**: Standard 30 **Stated:** First time	Where residents self-administer their medicines, the outcome of the risk assessment should be recorded and their competence to self-administer medicines should be confirmed in writing. One resident self-administered some of their medication. The outcome of the risk assessment had been recorded and competence to self-administer medicines had been confirmed in writing.	**Met**
Recommendation 6 **Ref**: Standard 30 **Stated:** First time	The registered person should develop Standard Operating Procedures regarding the management of controlled drugs. **Action taken as confirmed during the inspection**: Standard Operating Procedures regarding the management of controlled drugs had been written.	**Met**
Recommendation 7 **Ref**: Standard 31 **Stated:** First time	Obsolete personal medication record sheets should be promptly removed from the medicines file. **Action taken as confirmed during the inspection**: Only current personal medication record sheets were in the medicines files.	**Met**
Recommendation 8 **Ref**: Standard 32 **Stated:** First time	A medicines refrigerator should be purchased. **Action taken as confirmed during the inspection**: A medicines refrigerator had been purchased.	**Met**

4.3 Is care safe?

Medicines were managed by staff who had been trained and deemed competent to do so. There was an induction process in place. The impact of training was monitored through team meetings, supervision and appraisal. The registered manager confirmed that competency and capability assessments were performed annually; the last assessments were performed during April 2016. Staff completed eLearning update training in medicines management annually.

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. Handwritten entries on personal medication records and medicine 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 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. Daily checks were performed on controlled drugs which require safe custody.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturers' instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Only the current temperature of the medicines refrigerator was monitored and recorded daily; the registered manager gave an assurance that the temperature range would be monitored and recorded in future.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

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 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. A care plan was not maintained; a recommendation was made. The reason for and the outcome of administration were recorded.

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 the residents could verbalise any pain. A pain management care plan was not maintained; a recommendation was made.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged.

Practices for the management of medicines were audited throughout the month by management. The dates of opening were routinely recorded on medicine containers in order to facilitate audit activity; this good practice was recognised.

Following discussion with staff, it was evident that, when applicable, healthcare professionals were contacted in response to medicine related concerns or queries.

Areas for improvement

A care plan should be maintained for any resident prescribed medicines on a "when required "basis for the management of distressed reactions. A recommendation was made.

A care plan should be maintained for any resident prescribed medicines to control pain. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

Appropriate arrangements were in place to facilitate a resident responsible for the self-administration of some of their medicines.

The administration of medicines to residents was not observed at the inspection. Following discussion with residents and staff, it was ascertained that the residents were given time to take their medicines and were administered medicines in their preferred location e.g. bedroom, lounge or dining room.

Following discussion with three residents, no concerns in relation to the management of their medicines 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. Following discussion with staff, it was evident that they were familiar with the policies and procedures and that any updates were highlighted to them. They were also familiar with their roles and responsibilities in relation to medicines management.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. They also confirmed that there had been no medicine related incidents since the last medicines management inspection.

A review of the internal audit records indicated that good outcomes had been achieved.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated either individually with the staff member or through staff meetings.

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

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mr Hugh Warden, Registered Manager, 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 the 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 person/s 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 DHSSPS Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to 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 by the registered manager. 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 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 person/manager 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 person/manager 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 6 **Stated:** First time **To be completed by:** 3 June 2016	The management of distressed reactions should be reviewed to ensure that a care plan is maintained.
	Response by registered person detailing the actions taken: The care plans have been updated to cover the management of distressed reactions of a resident.
Recommendation 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 3 June 2016	Where residents are prescribed medicines to manage pain, this should be recorded in the care plan.
	Response by registered person detailing the actions taken: The care plans record details of medicines to manage.

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

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