The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report
5 February 2019

Summerhill

Type of service: Residential Care Home
Address: 31 Upper Gransha Road, Bangor, BT19 7QF
Tel No: 028 9146 1185
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 with 23 beds that provides care for residents as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Summerhill Residential Home Ltd **Responsible Individual:** Mr Hugh Fredrick Warden	**Registered Manager:** Mr Hugh Fredrick Warden
Person in charge at the time of inspection: Ms Sally Rea, Deputy Matron	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC): I – Old age not falling within any other category. DE – Dementia. PH(E) - Physical disability other than sensory impairment – over 65 years. SI – Sensory impairment.	**Number of registered places:** 23 This number includes a maximum of seven residents the DE category of care

4.0 Inspection summary

An unannounced inspection took place on 5 February 2019 from 10.30 to 14.10.

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 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 medicines administration, the majority of medicine records, storage and the management of controlled drugs.

Areas for improvement were identified in relation to the completion of personal medication records and care plans.

Residents said:

- “the care is fantastic”

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	0	*4

*The total number of areas for improvement include two, in relation to the standards, which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) 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.

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 10 July 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 medicine related incidents

During the inspection we met with two residents individually and spoke to others sitting in a lounge and dining room, two staff and the registered manager.

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 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 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
- controlled drug record book
- care plans
- training records
- 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 10 July 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 May 2016

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**
Recommendation 1 **Ref**: Standard 6 **Stated:** First time	The management of distressed reactions should be reviewed to ensure that a care plan is maintained. **Action taken as confirmed during the inspection**: Care plans for the management of distressed reactions were not in place. The staff advised that a new care planning system had commenced in January 2019 and they were still in the process of completing the information. The discussion with staff identified that they were unsure where and how the information should be included in the care plan (see Section 6.5).	**Not met**

	The area for improvement is restated.	
Recommendation 2 **Ref**: Standard 6 **Stated:** First time	Where residents are prescribed medicines to manage pain, this should be recorded in the care plan.	**Not met**
	Action taken as confirmed during the inspection: Care plans for the management of pain were not in place The staff advised that a new care planning system had commenced in January 2019 and they were still in the process of completing the information. The discussion with staff identified that they were unsure where and how the information should be included in the care plan (see Section 6.5). The area for improvement is restated.	

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 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 through e-learning in medicines management was completed 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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated but these additional entries were not signed by two members of staff. An area for improvement was identified.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. The registered manager advised that he was due to attend further training in a fortnight.

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. Checks were performed on controlled drugs which required safe custody, at the end of each shift.

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 manufacturer's 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. The medicine refrigerator temperature was checked at regular intervals.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission and controlled drugs.

Areas for improvement

Two staff should complete and sign all entries on the personal medication records (see Section 6.5).

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

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

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There were arrangements in place to alert staff of when doses of weekly medicines were due. The timing of the administration of bisphosphonate medicines was discussed. Staff advised that this had been approved by the general practitioners. It was agreed that this decision would be included in the care records.

Only one dose of a medicine prescribed on a "when required" basis for the management of distressed reactions had been administered in recent weeks. Dosage instructions were recorded on the personal medication record though the frequency was not recorded. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour. The reason for and the outcome of administration had been recorded. New care plans had been introduced the previous month and no information in relation to the management of distressed reactions had been documented. This was discussed and staff advised to refer to the care standards and their professional body for further advice. The area

for improvement previously identified in relation to this was restated (see Section 6.2) and another area in relation to staff training with regard to writing care plans 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. A care plan was not maintained. The area for improvement previously identified in relation to this was restated (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.

Medicine records were usually well maintained and facilitated the audit process. However, the personal medication records required improvement. All prescribed medicines should be included on the record, the frequency of administration of "when required" medicines should be included and all hand written entries on the records should be signed by two staff (see sections 6.4). An area for improvement in relation to the completion of personal medication records was stated.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines, nutritional supplements and inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist.

Following observation of a discussion between a member of staff and the community nurse, it was evident that other healthcare professionals are contacted in response to the health needs of the residents.

Areas of good practice

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

Areas for improvement

The areas for improvement in relation to the management of distressed reactions and pain management were restated for the second time.

New areas for improvement in relation to the completion of personal medication records and the training needs of staff on the completion of care plans were identified.

	Regulations	Standards
Total number of areas for improvement	0	2

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.

The administration of medicines to residents was not observed.

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

The lunch served during the inspection looked appetising and was being enjoyed by all the residents. Two residents said that it was lovely to get all their meals cooked and they didn't have to do it themselves.

Another resident observed that the staff were "fantastic" and their needs were met.

Of the questionnaires that were issued, 10 were returned from residents and none from relatives or staff. The responses indicated that they were very satisfied/satisfied with all aspects of the care in relation to the management of medicines. One response was shared, by telephone, with the registered manager for consideration.

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.

Written policies and procedures for the management of medicines were in place. Management advised that these were reviewed. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There were robust arrangements in place for the management of medicine related incidents. Staff advised that they knew how to identify and report incidents. One medicine related incident reported since the last medicines management inspection was discussed. In relation to the regional safeguarding procedures, staff advised that they were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. However, as two areas for improvement in relation to the standards made at the last medicines management inspection had not been addressed, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

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 with the exception of the need to maintain care plans for the management of distressed reactions and pain.

It was noted that personal medication records were stored on top of the medicine trolley and a filing cabinet of resident records was unlocked in a public area. The staff were reminded of the need for confidentiality for all records. This matter was addressed immediately

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

Areas of good practice

There were examples of good practice in relation to the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	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 Mr Hugh Warden, Registered Manager, 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

<table>
<tr><th colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 6

Stated: Second time

To be completed by: 5 March 2019</td><td>The management of distressed reactions should be reviewed to ensure that a care plan is maintained.

Ref: 6.2 and 6.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
All care plans have been updated to include agreed management of distressed reactions where appropriate.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 6

Stated: Second time

To be completed by: 5 March 2019</td><td>Where residents are prescribed medicines to manage pain, this should be recorded in the care plan.

Ref: 6.2 and 6.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
All care plans updated where pain management medicines are prescribed</td></tr>
<tr><td rowspan="2">Area for improvement 3

Ref: Standard 23

Stated: First time

To be completed by: 30 April 2019</td><td>The registered person shall ensure that staff are trained and competent in the completion of care plans.

Ref: 6.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
The new care plans are now fully implemented and staff clear on input required.</td></tr>
<tr><td rowspan="2">Area for improvement 4

Ref: Standard 6

Stated: First time

To be completed by: 5 March 2019</td><td>The registered person shall ensure all personal medication records are completed accurately.

Ref: 6.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
This has been completed.</td></tr>
</table>

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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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