Unannounced Medicines Management Inspection Report
31 August 2017

Tennent Street

Type of Service: Residential Care Home
Address: Hampton Suite, 1 Tennent Street, Belfast, BT13 3GD
Tel No: 028 9031 2318
Inspector: Judith Taylor

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 16 beds that provides care for residents within the categories of care the home is registered for, as described in the table in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Four Seasons Healthcare **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager:** See box below
Person in charge at the time of inspection: Ms Violet Graham	**Date manager registered:** Ms Violet Graham - application received - registration pending
Categories of care: Residential Care (RC) I – Old age not falling within any other category. DE – Dementia. MP – Mental disorder excluding learning disability or dementia. PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of registered places:** 16 MP – maximum 8 residents only

4.0 Inspection summary

An unannounced inspection took place on 31 August 2017 from 10.50 to 14.05.

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, medicine storage and the management of controlled drugs.

Areas requiring improvement were identified in relation to the standard of record keeping.

Residents spoke positively regarding the management of their medicines and the care provided to them.

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	*2

*The total number of areas for improvement includes one which has been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Ms Violet Graham, 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 16 May 2017. 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 reported to RQIA since the last medicines management inspection.

We met with three residents, two members of care staff and the 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
- controlled drug record book
- medicine audits
- policies and procedures
- 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 16 May 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 27 October 2015

Areas for improvement from the last medicines management inspection		
Area for improvement 1 **Ref**: Standard 31 **Stated:** First time	It is recommended that the transcribing of medicine information on medicine records is witnessed by two members of trained staff on every occasion.	**Not met**
	Action taken as confirmed during the inspection: There was little evidence that this practice occurred. **This area for improvement has been stated for a 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 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 was provided in the last year. The manager advised that a training session was to be held to discuss the inspection findings.

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

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.

The arrangements in place to manage changes to prescribed medicines should be reviewed. We found that when transcribing medicine details, the personal medication records and medication administration records (MARs) were not routinely updated by two members of staff. This is necessary to ensure safe practice. This issue had been raised at the previous medicines management inspection and the area of improvement has been stated for a second time.

The management of two new resident's medicines was reviewed. Staff confirmed that written confirmation of medicine regimes were received. However, this information could not be located at the time of the inspection. Details were provided to RQIA by email on 1 September 2017.

Records of the receipt and administration of controlled drugs were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift and also on other controlled drugs which is good practice.

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 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 controlled drugs and the storage of medicines.

Areas for improvement

Two staff should be involved in the updating of medicine records.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

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

The outcomes of the audit trails performed on a sample of medicines examined were mostly satisfactory, indicating that medicines had been administered in accordance with the prescriber's instructions. However, a discrepancy was noted in one inhaled medicine; the manager provided assurances that this inhaled medicine would be closely monitored with immediate effect. The audit trail on some other medicines could not be concluded as the there was no evidence of a record of the receipt of these medicines. See below.

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. Pain management was referenced in the care plans examined. Staff also advised that a pain assessment was completed as part of the admission process.

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.

Some of the medicine records were well maintained and facilitated the audit process. However, an area for improvement was identified in relation to personal medication records; a small number of the entries on the personal medication records and corresponding MARs did not correlate. These records must correlate and the personal medication record must be kept up to date at all times. An area for improvement was identified. As detailed above there was no evidence that the receipt of medicines records had been fully maintained. On 4 September the manager confirmed that a separate receipt of medicines record was maintained; however, this was not made available at the inspection. She advised that this would be raised at the upcoming staff training.

Following discussion with the manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to residents' healthcare needs.

Areas of good practice

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

Areas for improvement

A system should be in place to ensure that personal medication records are kept up to date at all times.

	Regulations	Standards
Total number of areas for improvement	0	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.

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.

Throughout the inspection, it was evident that there was a good rapport between residents and staff. The staff treated the residents with respect and their approach was friendly and kind. They listened to the residents' requests.

Residents advised that they were content with the management of their medicines and their care in the home. They spoke positively about the staff. Comments included:

"The staff are good here."
"They look after me."
"I like it here."

Of the questionnaires that were issued, five were returned from residents, two from relatives and one from staff. The responses indicated that they were very satisfied/satisfied with all aspects of the care in relation to the management of medicines. One comment made regarding timing of medicine administration was shared with the manager for information and action as required.

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. These were not examined at the inspection. Following discussion with staff it was evident that they were familiar with the policies and procedures.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicines, such as analgesics, laxatives and inhaled medicines. In addition, a quarterly audit was completed by the community pharmacist. A review of the audit records indicated that satisfactory outcomes had been achieved. Staff advised of the procedures in place to address any identified discrepancies.

Following discussion with manager and staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

The area for improvement made the last medicines management inspection had not been fully addressed. To ensure that this is fully addressed and the improvement sustained, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Staff confirmed that any medicines related concerns were raised with management. They advised that management were open and approachable and willing to listen. They stated that there were good working relationships within the home and with healthcare professionals involved in residents' care.

Areas of good practice

There were examples of good practice in relation to governance arrangements, 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 Ms Violet Graham, 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 Web Portal 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 the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 31 **Stated:** Second time	It is recommended that the transcribing of medicine information on medicine records is witnessed by two members of trained staff on every occasion. Ref: 6.2 & 6.4
To be completed by: 30 September 2017	**Response by registered person detailing the actions taken:** On the 6/9/2017 in house training was provided to all staff who administer medication to update them on best practice.Two staff are transcribing medicine information on medicine records Registered Manager is monitoring this practice during her daily walkarounds the home.
Area for improvement 2 **Ref**: Standard 31 **Stated:** First time	The registered person shall make the necessary arrangements to ensure that personal medication records are fully and accurately maintained at all times. Ref: 6.5
To be completed by: 30 September 2017	**Response by registered person detailing the actions taken:** Personal medication brought into the home are being recorded in the medicine receipt book which is located in the treatment room

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

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