Unannounced Medicines Management Inspection Report
24 November 2016

Willowview

Type of service: Residential Care Home
Address: 45 Killyleagh Road, Saintfield, BT24 7EH
Tel No: 028 9751 0878
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of Willowview took place on 24 November 2016 from 10.45 to 12.45.

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 the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. There were no areas of improvement identified.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure residents were receiving their medicines as prescribed. There were no areas of improvement identified.

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?

The service was 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. Systems were in place to enable management to identify and share learning from any medicine related incidents and medicine audit activity. There were no areas of improvement identified.

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	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Elizabeth Dolan, Registered Provider, as part of the inspection process and can be found in the main body of the report.

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 most recent inspection on 29 July 2016.

2.0 Service details

Registered organisation/registered person: Willowview/ Mrs Imelda Margaret Flanagan Mrs Elizabeth Joan Dolan	**Registered manager:** Mrs Imelda Margaret Flanagan
Person in charge of the home at the time of inspection: Mrs Elizabeth Joan Dolan	**Date manager registered:** 1 April 2005
Categories of care: RC-DE, RC-I, RC-PH	**Number of registered places:** 11

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home

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 two residents, one care assistant and the registered provider.

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. No one availed of this opportunity during the inspection.

A total of 15 questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA within one week. Six questionnaires were returned on the day of the inspection.

A sample of the following records was examined:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- medicine audits
- policies and procedures
- training records
- controlled drug record book

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 29 July 2016

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.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 7 May 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The date of receipt of medicines must be documented on the medicine administration record.	**Met**
	Action taken as confirmed during the inspection: The date of receipt of medicines had been recorded.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** Second time	Calogen must be refrigerated once opened.	**Met**
	Action taken as confirmed during the inspection: There were no residents prescribed Calogen at the time of this inspection, however the registered provider stated that it was refrigerated when in use.	
Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time	The registered person must ensure that all medicine entries on the medicine administration record sheets are permanent. Adhesive labels must not be used.	**Met**
	Action taken as confirmed during the inspection: All entries had been made in ink and adhesive labels were not used.	

Requirement 4 **Ref**: Regulation 13(4) **Stated:** First time	The controlled drugs record book must be fully and accurately maintained. **Action taken as confirmed during the inspection**: The controlled drugs record book had been appropriately maintained.	**Met**
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	The registered person should ensure that an epilepsy management plan is in place for the relevant residents. **Action taken as confirmed during the inspection**: Epilepsy management plans were not required by any of the residents at the time of this inspection. The registered provider was aware that they should be in place when necessary.	**Met**
Recommendation 2 **Ref**: Standard 30 **Stated:** First time	The registered person should ensure that policies and procedures which cover all aspects of the management of medicines are in place. These should include Standard Operating Procedures for the management of controlled drugs. **Action taken as confirmed during the inspection**: Policies and procedures were in place for the management of medicines including controlled drugs.	**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 team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was provided 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. The registered provider advised of the procedures to identify and report any potential shortfalls in medicines. A new sheet to identify medicines that were running low had been introduced.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on 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 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 require safe custody, at the end of each shift. Additional checks were also performed on other medicines which could be misused which is good practice.

Robust arrangements were observed for the management of high risk medicines eg 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 use of labelled medicine pots was explained by the registered provider who stated that medicines were prepared from the container they were dispensed in and administered to the residents in an appropriate way.

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. The management of bisphosphonates and the time of administration of this medicine were discussed with the registered provider.

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.

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.

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 well maintained and facilitated the audit process.

Practices for the management of medicines were audited throughout the month by the staff and management.

Following discussion with the registered provider, it was evident that other healthcare professionals are contacted when required to meet the needs of residents.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

The administration of medicines was not observed during this inspection. Interactions between staff and residents were observed to be caring and timely.

Questionnaires were completed by five residents and one resident's representative. All of the responses in the questionnaires indicated that residents were either "satisfied" or "very satisfied" with how medicines are managed in the home.

One member of staff completed the questionnaire. All of the responses were positive and raised no concerns with how medicines were managed within the home.

We spoke to two residents who expressed no concerns about the home. 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.

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.

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

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

Following discussion with the registered provider it was evident that there were clearly defined roles and responsibilities in relation to medicines management.

The requirements and recommendations made at the last medicines management inspection had been addressed.

The registered provider advised that any concerns in relation to medicines management were either raised with her or the registered manager. She reported that there are clear lines of communication with staff.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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