York House
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Portrush
BT56 8AY

Inspector: Judith Taylor
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Unannounced Medicines Management Inspection of York House

9 November 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced medicines management inspection took place on 9 November 2015 from 11:05 to 15:10.

The management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no significant areas of concern though some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report. Areas of good practice were acknowledged.

This inspection was underpinned by the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

1.1 Actions/Enforcement Taken Following the Last Medicines Management Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last medicines management inspection on 30 November 2012.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	2

The details of the QIP within this report were discussed with Mrs Hazel Walker, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Presbyterian Board of Social Witness Mrs Linda May Wray	**Registered Manager:** Mrs Hazel Elizabeth Mary Walker
Person in Charge of the Home at the Time of Inspection: Mrs Hazel Elizabeth Mary Walker	**Date Manager Registered:** 1 April 2005
Categories of Care: RC-DE, RC-PH(E), RC-I, RC-MP(E)	**Number of Registered Places:** 32
Number of Residents Accommodated on Day of Inspection: 26	**Weekly Tariff at Time of Inspection:** £470

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and to determine if the following standards and themes have been met:

Standard 30: Management of Medicines
Standard 31: Medicines Records
Standard 33: Administration of medicines

Theme 1: Medicines prescribed on a "when required" basis for the management of distressed reactions are administered and managed appropriately

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately

4. Methods/Process

Specific methods/processes used in this inspection include the following:

We met with the registered manager and the two senior care staff on duty.

The following records were examined:

- Medicines requested and received
- Personal medication records
- Medicines administration records
- Medicines disposed of
- Controlled drug record books
- Medicines transferred.
- Medicine audits
- Policies and procedures
- Care plans
- Training records
- Medicine storage temperatures

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an announced finance inspection dated 29 September 2015. The completed QIP will be assessed by the finance inspector.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Inspection

No requirements were made.

Last Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 30 **Stated**: First time	The registered manager should ensure that when personal medication records are not verified and signed by the prescriber, a copy of the most recent prescription is kept in the home and replaced when any changes are made; and two staff are involved in recording the new medicine details onto the personal medication record.	**Met**
	Action taken as confirmed during the inspection: A copy of the most recent prescriptions was kept in the home. New medicine entries on personal medication records were initialled by two members of trained staff.	
Recommendation 2 **Ref**: Standard 30 **Stated**: First time	The registered manager should include the management of warfarin in the audit process.	**Met**
	Action taken as confirmed during the inspection: Satisfactory arrangements were in place for the auditing of warfarin. All opened containers of warfarin were audited on a daily basis.	
Recommendation 3 **Ref**: Standard 30 **Stated**: First time	The registered manager should develop and implement written standard operating procedures for controlled drugs.	**Met**
	Action taken as confirmed during the inspection: Witten standard operating procedures for the management of controlled drugs were in place.	
Recommendation 4 **Ref**: Standard 31 **Stated**: First time	The registered manager should add the necessary details to the controlled drug record book.	**Met**
	Action taken as confirmed during the inspection: A new controlled drug record book had been obtained and the necessary improvements implemented.	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

Several medicines and medicine records were audited at the inspection. The audits produced satisfactory outcomes indicating medicines were administered as prescribed. Bisphosphonate medicines had been administered in accordance with the manufacturers' instructions.

There was evidence of the arrangements to ensure the safe management of medicines during a resident's admission to the home and discharge from the home. Medicine details were confirmed with the prescriber and personal medication records were completed and checked and initialled by two trained staff.

Care plans/protocols for the management of hypoglycaemia and epilepsy were in place where necessary.

Systems to manage the ordering of prescribed medicines, to ensure that adequate supplies were available, were reviewed. These were found to be satisfactory. All of the medicines examined at the inspection were labelled appropriately.

There were robust arrangements for managing medicine changes, including high risk medicines such as warfarin and insulin; all changes were confirmed in writing and records were updated by two trained staff. This is safe practice.

Most of the medicine records were legible and accurately maintained so as to ensure that there was a clear audit trail. Records of the prescribing, ordering, receipt, administration, non-administration and disposal and transfer of medicines were maintained. Some areas for improvement were identified on the personal medication records and were being addressed during the inspection.

The receipt, storage, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Stock reconciliation checks were performed on controlled drugs which require safe custody, at each transfer of responsibility.

Any medicines which were discontinued or were unsuitable for use were returned to the community pharmacy for disposal.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines, including Standard Operating Procedures for the management of controlled drugs in York House were available.

Medicines were managed by staff who had been trained and deemed competent to do so. The registered manager advised that the impact of training was monitored through supervision and annual appraisal. Staff competency in medicines management was reviewed annually. Recent training had included the management of diabetes and oxygen. However, records of this training had not been maintained. It was agreed that the training records would be updated at the earliest opportunity to include the recent training on the management of diabetes, including blood glucose monitoring and also the management of oxygen.

A list of the names, initials and sample signatures of staff responsible for administering medicines was maintained.

Arrangements were in place to audit the practices for the management of medicines. They included the maintenance of a running stock balance for analgesics and oral nutritional supplements, and random spot checks on records and medicines throughout the month. A review of the audit records indicated that largely satisfactory outcomes had been achieved. The audit process was facilitated by the good practice of recording the date and time of opening on medicine containers.

Staff confirmed that compliance with prescribed medicines regimes was monitored and any omissions or refusals likely to have an adverse effect on the residents' health were reported to the prescriber.

There were procedures in place to report and learn from any medicine related incidents that may occur in the home. There had been no reported medicine related incidents since the last medicines management inspection.

Is Care Compassionate? (Quality of Care)

The records pertaining to a small number of residents who were prescribed medicines for the management of distressed reactions, on a "when required" basis were reviewed at the inspection. The name of the medicine was documented on the personal medication record and the frequency of dosing was recorded. The evidence indicated that these medicines were rarely administered. A care plan was not in place and a recommendation was made. From discussion with staff, it was concluded that staff were familiar with circumstances when to administer anxiolytic/antipsychotic medicines and were aware that a change in a resident's behaviour may be associated with pain.

The sample of records examined indicated that medicines which were prescribed to manage pain were recorded on the resident's personal medication record and 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. Care plans in relation to pain management were maintained for some but not all of the residents prescribed pain controlling medicines. A recommendation was made. Staff advised that all residents could verbalise pain.

There was evidence that the formulation of medicines had been changed to suit the resident's swallowing needs.

Areas for Improvement

The management of distressed reactions should be reviewed to ensure that a detailed care plan is developed for any resident prescribed anxiolytic/ antipsychotic medicines on a "when required" basis. A recommendation was made.

The management of pain should be reviewed to ensure that a detailed care plan is maintained for those residents who are prescribed medicines to manage pain. A recommendation was made.

Number of Requirements	0	**Number of Recommendations**	2

5.4 Additional Areas Examined

Medicines were stored safely and securely. Largely satisfactory arrangements were in place to monitor the temperatures of medicine storage areas. It was noted the maximum and minimum temperatures for the medicine refrigerator were almost the same each day and this was discussed. The staff confirmed that the thermometer was reset each day. It was agreed that these temperatures would be closely monitored as part of the audit process.

Robust systems were in place for the key control of medicine cupboards. A separate log book was maintained to record the handover of medicine keys.

Staff were reminded that sachets of plasters for the treatment of pain, must be sealed after each use, as per manufacturers' instructions.

6 Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Hazel Walker, 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 RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The DHPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Residential Care Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

Actions Taken by the Registered Manager/Registered Person

The QIP should be completed by the registered manager/registered person and 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. 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 weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

No requirements were made following the inspection.

Recommendations

Recommendation 1 **Ref**: Standard 6 **Stated**: First time **To be Completed by:** 9 December 2015	A care plan should be developed for any resident prescribed medicines on a “when required basis” for the management of distressed reactions.
	Response by Registered Person(s) Detailing the Actions Taken: Care Plans for residents prescribed medicines on a "when required basis" for distressed reactions have now been updated. This procedure is now put in place for all residents requiring this management.
Recommendation 2 **Ref**: Standard 6 **Stated**: First time **To be Completed by**: 9 December 2015	A care plan should be developed for any resident prescribed medicines for the management of pain.
	Response by Registered Person(s) Detailing the Actions Taken: Care Plans for the management of residents prescribed medicinesfor the management have now been updated. This procedure is now put in place for all residents requiring this management.

Registered Manager Completing QIP	Hazel Walker	**Date Completed**	8.12.15
Registered Person Approving QIP	Linda Wray	**Date Approved**	16/12/2015
RQIA Inspector Assessing Response	Judith Taylor	**Date Approved**	16/12/15

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