

# Unannounced Medicines Management Inspection Report 27 June 2016



## SENSE

Type of Service: Residential Care Home  
Address: 41 Edenvale Avenue, Eden, Carrickfergus, BT38 7NP  
Tel No: 028 9336 2792  
Inspector: Judith Taylor

[www.rgia.org.uk](http://www.rgia.org.uk)

Assurance, Challenge and Improvement in Health and Social Care

## 1.0 Summary

An unannounced inspection of SENSE took place on 27 June 2016 from 10.35 to 13.15.

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 residents. Staff were trained and competent and there were robust processes for the stock control of medicines and management of medicines changes. One recommendation in relation to the management of insulin has been made. No requirements have been made.

### **Is care effective?**

There was evidence that the management of medicines supported the delivery of effective care. There were systems in place to ensure that the residents were administered their medicines as prescribed. Two recommendations in relation to pain management and record keeping have been made. No requirements were made.

### **Is care compassionate?**

There was evidence that the management of medicines supported the delivery of compassionate care. Arrangements were in place to ensure that medicines were administered to residents in a caring and timely manner and to maintain dignity and privacy. No requirements or recommendations have been made.

### **Is the service well led?**

There was evidence that the service was well led with respect to the management of medicines. Written medicine policies and procedures were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. 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
<b>Total number of requirements and recommendations made at this inspection</b>	0	3

Details of the QIP within this report were discussed with Mrs Margaret McKinstry, Senior Support Worker at the inspection and with Mr Patrick Black, Applicant Manager, by telephone on 28 June 2016, 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 most recent inspection on 9 December 2015.

The estates support officer carried out a follow up visit on 1 March 2016 to review the position in relation to the issues contained in the QIP for the last premises inspection.

## 2.0 Service details

<b>Registered organisation/ registered provider:</b> Mrs Collette Gray	<b>Registered manager:</b> Mr Patrick Black – application received
<b>Person in charge of the home at the time of inspection:</b> Mrs Margaret McKinstry	<b>Date manager registered:</b> Registration Pending
<b>Categories of care:</b> RC-SI	<b>Number of registered places:</b> 10

### 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.

We met with two members of staff.

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 9 December 2015

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 their next inspection. The estates inspector and the estates support officer will follow up the outstanding premises issues identified during the visit on 1 March 2016.

#### 4.2 Review of requirements and recommendations from the last medicines management inspection dated 13 September 2013

Last medicines management inspection statutory requirements		Validation of compliance
<b>Requirement 1</b> <b>Ref:</b> Regulation 13(4) <b>Stated:</b> First time	<p>The registered person must ensure that minimum and maximum refrigerator temperatures are monitored and recorded on a daily basis.</p> <p><b>Action taken as confirmed during the inspection:</b>            There was evidence that daily minimum and maximum refrigerator temperatures were recorded.</p>	<b>Met</b>
Last medicines management inspection recommendations		Validation of compliance
<b>Recommendation 1</b> <b>Ref:</b> Standard 31 <b>Stated:</b> First time	<p>The registered person should ensure that all transcribing on medicine records involves two staff and both staff sign the entry on each occasion.</p> <p><b>Action taken as confirmed during the inspection:</b>            The sample of records examined indicated that two staff were involved in the transcribing of new medicine details on records.</p>	<b>Met</b>
<b>Recommendation 2</b> <b>Ref:</b> Standard 31 <b>Stated:</b> First time	<p>The registered person should closely monitor the completion of MARs for those medicines which are prescribed at specific intervals.</p> <p><b>Action taken as confirmed during the inspection:</b>            Improvements were noted in the management of medicines prescribed at specific intervals. However, some unexplained omissions were noted and discussed with the manager and staff. The manager advised that the MAR would be marked out with the specific days of administration for future doses. Due to the assurances provided by the manager, this recommendation has not been stated for a second time.</p>	<b>Met</b>

### 4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in general medicines management was provided in the last year. The management of diabetes was discussed. There was evidence of training on the management of diabetes on some staff records; however, where the training had been cascaded to other staff, this was not always recorded. It was agreed with the manager that this would be added to the training records at the earliest opportunity.

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. Personal medication 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 and when on periods of temporary leave from the home.

The management of insulin was reviewed. This medicine was administered by the community nurses. It was advised that the personal medication record should be updated as the current dosage recorded was incorrect and there should be reference as to who is responsible for administration. A care plan was maintained in the community nurses notes; however, the care plan maintained by the staff did not state that insulin was prescribed. A plan for the management of hypoglycaemia was in place. This care plan should be updated. A recommendation was made.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and most were stored in accordance with the manufacturer's instructions. It was noted that the room temperature of one of the treatment rooms has been above the accepted upper limit of 25°C. A fan had been brought into use. The manager advised that this had been identified and was being reviewed through the maintenance department.

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 and medicines which were due to expire within the next few months. Medicine refrigerators were checked each day.

#### Areas for improvement

The management of insulin should be reviewed to ensure that this is clearly referenced in the personal medication record and the resident's care plan. A recommendation was made.

<b>Number of requirements</b>	<b>0</b>	<b>Number of recommendations</b>	<b>1</b>
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#### 4.4 Is care effective?

Most of the medicines examined at the inspection had been administered in accordance with the prescriber's instructions. One discrepancy in a liquid medicine was highlighted and it was agreed that this would be closely monitored. A small number of medicines were prescribed two or three times per week; whilst most of these were administered as prescribed, a small number of omissions were observed. It was agreed that the days these medicines were due for administration would be highlighted on the medication administration records.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. It was noted that two paracetamol containing medicines were prescribed for some residents; it was confirmed that staff were aware of this and knew that these two medicines could not be administered at the same time. It was agreed that warning alerts would be recorded on the personal medication records. Staff advised that following the administration of pain relief, the resident was closely monitored to ensure that they were comfortable. Staff advised that some residents could tell the staff they were in pain and could ask for pain relief. The management of pain for those residents who were unable to verbalise pain was discussed. The management of pain should be referenced in the care plan. A recommendation was made.

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

The majority of medicine records were well maintained and facilitated the audit process. A small number of incomplete records of medicines administered was noted in the current medicine cycle. Cross reference with some the medicine blister packs indicated the medicines had been administered, but had not been signed for. Whilst there is a system in the home, where a second member of staff witnesses the administration of medicines, this system should be reviewed to ensure that the records are accurately completed. A recommendation was made. It was suggested that records should be checked at the end of each medicine round or daily to ensure that they are fully completed.

Practices for the management of medicines were audited throughout the month by the staff and management. Each resident's medicines were audited per week, and stock balances were recorded. The date of opening was routinely recorded on medicines which facilitated the audit process. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to issues or concerns in response to medicines management.

#### Areas for improvement

The management of pain should be reviewed to ensure that this is detailed in a care plan for the resident. A recommendation was made.

The process for the administration of medicines should be reviewed to ensure that the records are fully completed. A recommendation was made.

<b>Number of requirements</b>	<b>0</b>	<b>Number of recommendations</b>	<b>2</b>
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#### 4.5 Is care compassionate?

The administration of medicines to residents was not observed at this inspection. With the exception of one resident, the other residents were out with staff or at the day centre.

Following discussion with staff it was established that medicines were administered in a caring manner, residents were given time to take their medicines and medicines were administered as discreetly as possible.

It was not possible to obtain the views or opinion of residents.

#### Areas for improvement

No areas for improvement were identified during the inspection.

<b>Number of requirements</b>	<b>0</b>	<b>Number of recommendations</b>	<b>0</b>
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#### 4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. These should be updated with reference to the current legislation. The manager agreed to review this. 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 confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. Staff advised of the learning which had occurred and had resulted in a change of practice.

A review of the internal audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken. Outcomes were shared with staff through the use of the communication book and team meetings.

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

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

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated through individual meetings, staff meetings or supervision.

#### Areas for improvement

No areas for improvement were identified during the inspection.

<b>Number of requirements</b>	<b>0</b>	<b>Number of recommendations</b>	<b>0</b>
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## 5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Margaret McKinstry, Senior Support Worker, and Mr Patrick Black, Applicant Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 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.

## 5.1 Statutory requirements

This section outlines the actions which must be taken so that the 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 The 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 provider/manager may enhance service, quality and delivery.

## 5.3 Actions taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements stated. The registered provider should confirm that these actions have been completed and return completed QIP to [pharmacists@rqia.org.uk](mailto:pharmacists@rqia.org.uk) for review 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 provider 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 provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

## Quality Improvement Plan

<b>Recommendations</b>	
<p><b>Recommendation 1</b></p> <p>Ref: Standard 30</p> <p>Stated: First time</p> <p>To be completed by: 27 July 2016</p>	<p>The registered provider should review the management of insulin to ensure that this is clearly referenced in the resident's personal medication record and care plan.</p> <hr/> <p><b>Response by registered provider detailing the actions taken:</b> The individual medication kardex has been reviewed and updated to reflect that community nursing administer the insulin and dosage has been changed to varies and to refer to community nursing care plan for most up-to-date dosage. The care plan has been updated to reflect more clearly that insulin is prescribed.</p>
<p><b>Recommendation 2</b></p> <p>Ref: Standard 6</p> <p>Stated: First time</p> <p>To be completed by: 27 July 2016</p>	<p>The registered provider should review the management of pain to ensure this is referenced in a care plan for the relevant residents.</p> <hr/> <p><b>Response by registered provider detailing the actions taken:</b> There are now guidelines for the management of pain in each individual's care plan.</p>
<p><b>Recommendation 3</b></p> <p>Ref: Standard 31</p> <p>Stated: First time</p> <p>To be completed by: 27 July 2016</p>	<p>The registered provider should review the administration of medicines process to ensure that a record of the administration or non-administration of a medicine is recorded on every occasion.</p> <hr/> <p><b>Response by registered provider detailing the actions taken:</b> The current system has been reviewed and good practice of checking that all signatures are present is being emphasised through the current medication assessments of competency with all staff.</p>

*\*Please ensure this document is completed in full and returned to [pharmacists@rqia.org.uk](mailto:pharmacists@rqia.org.uk) from the authorised email address\**



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