The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report
15 September 2017

Garryduff House

Type of service: Residential Care Home
Address: 2 Garryduff Road, Ballymoney, BT53 7AF
Tel No: 028 2766 6220
Inspector: Judith Taylor

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 seven beds that provides care for adults living with learning disability.

3.0 Service details

Organisation/Registered Provider: Triangle Housing Association **Responsible Individual:** Mr Christopher Harold Alexander	**Registered Manager:** Ms Jacqueline Pearl Peacock
Person in charge at the time of inspection: Ms Jacqueline Pearl Peacock	**Date manager registered:** 1 April 2015
Categories of care: Residential Care (RC) LD – Learning disability LD(E) – Learning disability – over 65 years	**Number of registered places:** 7

4.0 Inspection summary

An unannounced inspection took place on 15 September 2017 from 10.50 to 13.10.

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 the governance arrangements for medicines, the standard of record keeping and care plans and the storage of medicines.

No areas for improvement were identified at the inspection.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Jacqueline Peacock, Registered Manager, and one other member of staff, 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.

4.2 Action/enforcement taken following the most recent care inspection

No further actions were required to be taken following the most recent inspection on 16 May 2017. 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.

During the inspection the inspector met with one resident, one member of care staff and the registered manager.

A total of 15 questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA.

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
- medicine audits
- policies and procedures
- care plans
- training record

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. There were no areas for improvement made as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 16 April 2015

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 30 **Stated:** First time	It is recommended that the registered person should ensure that a care plan is maintained for residents who are prescribed medicines for the management of pain, on a 'when required' basis.	**Met**
	Action taken as confirmed during the inspection: There was evidence that pain management was referenced in the sample of care plans examined.	

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. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. The medicines management competency assessment document had been revised this month. The most recent training in relation to medicines management had been completed in February 2017.

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.

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.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed for all staff in the last year.

There were procedures in place to ensure the safe management of medicines during a resident's temporary absence from the home.

Discontinued or expired medicines were disposed of appropriately.

Since the last medicines management inspection, the storage of medicines had been reviewed. Individual cupboards/drawers had been obtained specifically for medicines and these were located in each resident's bedroom. These were locked securely and the medicines were stored in accordance with the manufacturer's instructions. Internal and external medicines were segregated. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Staff advised that this new system worked well and facilitated the safe administration of medicines due to a reduction in the risk of distractions.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	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. These satisfactory outcomes were acknowledged.

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 and were aware that this change may be associated with pain. These medicines had not been required to be administered for some time. A care plan was maintained.

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 in place and detailed how the resident would express pain.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Each administration was recorded and a care plan and speech and language assessment report was in place. It was agreed that one care plan would be updated to reflect the most recent assessment.

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. They also confirmed that the residents were compliant with their medicine regimes.

Medicine records were well maintained and facilitated the audit process. The good standard of record keeping was acknowledged. Areas of good practice included the use of separate administration records for antibiotics; the maintenance of protocols and running stock balances for medicines prescribed on a 'when required' basis; and the site of application for external preparations being recorded on personal medication records.

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

Areas of good practice

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

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

There were no medicines which required administration during the time of the inspection.

Following discussion with staff, it was confirmed that the residents were given as much time as needed to take their medicines and medicines were administered in accordance with their preferences. Examples of these preferences were provided and details were recorded in the resident's care files.

As mentioned earlier in the report, the residents' medicines were now stored in their bedroom. Staff advised of the benefits this had in relation to spending time with the resident and privacy for the resident.

We met briefly with one resident, who was able to confirm that she was happy in the home and could take her medicines. For those residents who could not verbalise their feelings in respect of their care, we noted them to be relaxed and comfortable in their surroundings and in their interactions with staff.

Of the questionnaires that were issued, two were returned from relatives and three from staff. The responses indicated that they were very satisfied/satisfied with all aspects of the care in relation to the management of medicines.

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 regularly. The safeguarding policy had been reviewed in April 2017. 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. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

An effective auditing system was in place. Medicines management was audited each week by the staff and monthly audits were completed by management. We were also advised that a full audit of one resident’s medicines and care records was undertaken each month. Staff advised of the procedures which would be followed if a discrepancy or an area for improvement was identified.

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.

It was confirmed that any concerns in relation to medicines management were raised with the management. We were advised that management were open and approachable and that there were good working relationships within the home and with other healthcare professionals involved in resident 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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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