Unannounced Medicines Management Inspection Report
6 April 2016

Karuna Home

3 - 5 Minorca Drive, Ellis Street, Carrickfergus, BT38 8WP
Tel No: 028 9336 0665
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Karuna Home took place on 6 April 2016 from 10.30 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.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

Is care safe?
No requirements or recommendations have been made.

Is care effective?
One recommendation has been made.

Is care compassionate?
One recommendation has been made.

Is the service well led?
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
Total number of requirements and recommendations made at this inspection	0	2

The details of the QIP within this report were discussed with the Registered Manager, Mrs Heather Wright, who was present during the inspection. 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

There were no further actions required to be taken following the most recent inspection on 17 November 2015.

2.0 Service details

Registered organisation/registered person: The Cedar Foundation/ Ms Eileen Marian Thomson	**Registered manager:** Mrs Heather Denise Wright
Person in charge of the home at the time of inspection: Mr Owen McCabe (Practice Leader)	**Date manager registered:** 1 April 2005
Categories of care: RC-LD, RC-LD(E)	**Number of registered places:** 9

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 one resident and two members of staff.

The following records were 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 17 November 2015

The most recent inspection of the home was an unannounced care inspection. No requirements or recommendations were made and therefore a QIP was not issued as a result of the inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 27 September 2013

Last medicine management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	The registered manager should further develop the policies and procedures to include swallowing difficulty and the use of thickening agents.	**Met**
	Action taken as confirmed during the inspection: A procedure for the management of swallowing difficulty and use of thickening agents was detailed in a policy.	
Recommendation 2 **Ref**: Standard 31 **Stated:** First time	The registered manager should ensure that where medicine entries are transcribed onto medication administration records (MARS), two staff should initial the entry on every occasion.	**Met**
	Action taken as confirmed during the inspection: There was no evidence of any handwritten medicine entries on the MARs. The registered manager advised that following a review, a printed MAR sheet is now obtained for all new medicines or medicine dosage changes. Staff no longer record entries on the MARs. As written this recommendation could not be examined; however, there are robust systems in place to ensure that medicine entries are accurate.	
Recommendation 3 **Ref**: Standard 31 **Stated:** First time	The registered manager should closely monitor the records of administration to ensure that where medicines are prescribed as a 'variable dose', the actual quantity of medicine administered is recorded on every occasion.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that medicines prescribed as a variable dosage had been reviewed with the prescriber, following the last inspection. The records examined indicated that variable dose medicines were rarely prescribed. There was no evidence of any medicines administered at a variable dose. She confirmed that when applicable, the variable dose would be clearly indicated in the running stock balance records and also the administration records.	

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 general medicines management, epilepsy awareness and external preparations was provided in the last year. Training in the management of swallowing difficulty was planned for later in the year.

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 discharge from the home.

Records of the receipt, administration and disposal 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.

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. Medicine refrigerators were checked at regular intervals.

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 were arrangements in place to alert staff of when doses of weekly medicines were due.

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 were administered infrequently. A care plan was not

maintained and a recommendation was made. It was agreed that the reason for and outcome of any administration would be recorded from the day of the inspection onwards.

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 communication passport was maintained for each resident, this included the management of pain and how this may be expressed by the resident. This is good practice. A care plan was maintained.

The management of swallowing difficulty was examined. There was evidence that staff were aware of the prescribed consistency level of thickened fluid prescribed. Each administration was recorded. A care plan and speech and language assessment report was in place.

Epilepsy management plans were maintained.

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. Areas of good practice were acknowledged. They included records of the date of opening of medicines, quantities of medicines carried forward into the next medicine cycle and separate administration records for transdermal medicines.

Practices for the management of medicines were audited throughout the month by the staff. This included running stock balances for several medicines not included in the 28 day blister packs e.g. analgesics, liquids and nutritional supplements. A detailed monthly audit was completed by the registered manager. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to medicine related concerns or queries.

Areas for improvement

A care plan should be maintained for any resident prescribed medicines on a "when required" basis for the management of distressed reactions. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

The administration of medicines to residents was not observed at the inspection. Following discussion with staff it was ascertained that the residents were given time to take their medicines and residents were administered their medicines in their preferred location, e.g. bedroom, lounge or dining room.

It was noted that in order to meet the resident's needs, some medicines were placed in oral nutritional supplements to aid swallowing. This was not recorded in the care plan and there was no evidence of any pharmaceutical advice regarding this arrangement. A recommendation was made.

The resident's communication passport clearly stated the resident's own views around medicine administration.

Following discussion with the resident, no concerns in relation to the management of their medicines were raised.

Areas for improvement

The addition of medicines to nutritional supplements to facilitate administration should be recorded in the care plan and pharmaceutical advice regarding the suitability of this should be obtained. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. 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. The medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and the learning implemented.

A review of the internal audit records indicated that satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and the learning which had resulted in a change of practice.

Staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated through team meetings.

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

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Mrs Heather Wright, 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s 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 DHSSPS Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to 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 by the registered manager. 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 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 person/manager 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 person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 7 May 2016	The management of distressed reactions should be reviewed to ensure that a care plan is maintained.
	Response by Registered Person(s) detailing the actions taken: Care Plans are in place for all those residents who received PRN medication and clear guidance as to when this should be administered.
Recommendation 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 7 May 2016	Where medicines are administered with nutritional supplements to aid swallowing, pharmaceutical advice should be sought and a care plan should be maintained.
	Response by Registered Person(s) detailing the actions taken: Advice sought from pharmacist and staff adhering to guidance. Care plan updated to reflect procedure being followed when administering medication.

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