Unannounced Medicines Management Inspection Report
22 September 2016

Ross Lodge/Ross House

Type of Service: Residential Care Home
Address: 288 Moyarget Road, Dervock, Ballymoney, BT53 8EG
Tel No: 028 2074 1490
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Ross Lodge/Ross House took place on 22 September 2016 from 10.20 to 14.05.

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 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. No requirements or recommendations were made.

Is care effective?

Most areas of the management of medicines supported the delivery of effective care. There were systems in place to ensure residents were receiving their medicines as prescribed. Two areas for improvement were identified in relation to care planning and record keeping. Two recommendations were made.

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. No requirements or recommendations were made.

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. These were currently being revised. Systems were in place to enable management to identify and cascade learning from incidents and medicine audit activity. No requirements or recommendations were 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

Details of the Quality Improvement Plan (QIP) within this report were discussed with the manager, Ms Dorothy McClements, 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 25 August 2016.

2.0 Service details

Registered organisation/registered person: Mr Alex McKinney and Mrs Joyce McKinney	**Registered manager:** See below
Person in charge of the home at the time of inspection: Mrs Dorothy McClements	**Date manager registered:** Mrs Dorothy McClements (Acting Manager – No application)
Categories of care: RC-LD, RC-LD(E), RC-PH, RC-PH(E)	**Number of registered places:** 13

3.0 Methods/processes

Prior to inspection we analysed the following records:

- 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 three residents, two care staff and the manager.

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 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 records

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 25 August 2016

The most recent inspection of the home was an unannounced care inspection. A report has been issued to the home. The completed QIP will be assessed by the care inspector and will be validated at the next care inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 30 May 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must investigate the observation made in risperidone liquid and cetirizine tablets; a written report detailing the findings and action taken must be forwarded to RQIA.	**Met**
	Action taken as confirmed during the inspection: The registered manager had forwarded details of the investigation and the corrective action taken to RQIA.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must ensure that robust arrangements are in place to confirm and record medicine regimes for residents at each period of respite care.	**Met**
	Action taken as confirmed during the inspection: The manager advised of the procedures in place to ensure that up to date medicine information is received for all residents at each period of respite care. There were also systems in place to follow up any medicines which were prescribed but had not been received/supplied.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** Second time	Policies and procedures for the management of medicines should be further developed to include: • personal medication records • warfarin and • thickening agents	**Met**
	Action taken as confirmed during the inspection: The returned QIP from the last medicines management inspection stated that this recommendation was being addressed. The policies included reference to personal medication records and warfarin. However, the policy and procedures regarding thickening agents could not be located. This was provided by email following the inspection.	
Recommendation 2 **Ref**: Standard 30 **Stated:** Second time	The date of opening should be recorded on all medicine containers in Ross House.	**Met**
	Action taken as confirmed during the inspection: Medicines were marked with the date of opening.	
Recommendation 3 **Ref**: Standard 30 **Stated:** Second time	The registered manager should develop written standard operating procedures for controlled drugs.	**Met**
	Action taken as confirmed during the inspection: There were policies and procedures to direct the management of controlled drugs.	
Recommendation 4 **Ref**: Standard 30 **Stated:** Second time	The audit process should cover all aspects of medicines management as identified by the areas noted for improvement in the report.	**Met**
	Action taken as confirmed during the inspection: A robust auditing process was evidenced at the inspection. A daily audit is undertaken for all medicines prescribed for permanent residents. Spot checks are also undertaken on a regular basis for medicines prescribed for residents receiving respite care.	

Recommendation 5 **Ref**: Standard 31 **Stated:** First time	The registered manager should closely monitor the personal medication records as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: The sample of records observed had been generally well maintained. The manager confirmed that personal medication records were reviewed on a regular basis.	

4.3 Is care safe?

The manager confirmed that medicines were managed by staff who have been trained and deemed competent to do so. A sample of induction, competency assessment and training records were made available at the inspection. The most recent training in medicines management was in May 2016. For the new staff, records of induction, training and competency had not yet been maintained. This was commenced during the inspection. The manager advised of the areas which she had identified for improvement and advised that further training was planned.

The procedures to review the impact of training were discussed. The manager advised that, due to the recent changes in management, the planned programme of supervision, competency and appraisal had not been adhered to. She confirmed that this was an area that was a work in progress and also that team meetings were used to raise any areas for improvement in relation to medicines management.

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. Medicine orders for repeat medicines were not made by the staff and staff did not review the prescriptions prior to dispensing. This is best practice and was discussed with reference to the Health and Social Care Board guidance. It was agreed that this would be reviewed.

There were satisfactory arrangements in place to manage changes to prescribed medicines. These were usually recorded on the personal medication record by the prescriber. Staff were reminded that where they have to add information to the personal medication records, the information should be verified and signed by two designated members of staff. The manager advised that this would be raised with staff. It was acknowledged that updated personal medication records had been recently forwarded to the prescriber for verification and signing.

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.

Controlled drugs which require safe custody were not prescribed for any residents accommodated in the home.

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.

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.

A staff communication book was maintained and viewed at each shift change. This included information regarding medicines and the outcomes of visits from/consultation with other healthcare professionals.

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. The reason for and the outcome of administration were recorded on some but not all occasions. A care plan was not maintained. A recommendation was made.

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. For those residents who could not verbalise pain, staff advised of how this would be expressed. This information should be recorded in the resident's 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 the resident's health were reported to the prescriber.

Medicine records were well maintained and facilitated the audit process.

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

Areas for improvement

The management of medicines prescribed for distressed reactions should be reviewed to ensure that this is detailed in the resident's care plan and the reason for and outcome of any administration is recorded. A recommendation was made.

For residents who are unable to verbalise pain, details of how pain is expressed and managed should be recorded in the resident's care plan. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

The administration of medicines to residents was not observed at the time of the inspection. Following discussion with staff it was ascertained that medicines were administered in a caring manner, residents were given time to take their medicines and medicines were administered as discreetly as possible.

We met with three residents who were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. They spoke positively about their care in the home.

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?

Whilst there was evidence that new written policies and procedures for the management of medicines were being developed and were in draft form, a copy of the current policies could not initially be located in either Ross Lodge or Ross House. Policies and procedures must be readily available for staff at all times. The manager agreed to ensure that a copy of medicines management policies was kept in both Ross Lodge and Ross House.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents.

A robust system to audit the management of medicines was evidenced at the inspection. A daily running stock balance was maintained for each medicine prescribed for residents who were accommodated on a permanent basis; this is good practice and was facilitated by the maintenance of a separate audit book per resident. Spot checks on stock balances of medicines were also completed for residents in receipt of respite care. The manager advised of the procedures that would be followed in the event of a discrepancy.

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 requirements and recommendations made at the last medicines management inspection had been addressed. As part of best practice, and the manager's new role, it was suggested that the QIP should be regularly reviewed as part of the quality improvement process.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with them directly or via 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

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Dorothy McClements, 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 registered provider 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 to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to pharmacists@rqia.org.uk for assessment 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	
Recommendations	
Recommendation 1 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 22 October 2016	The registered provider should ensure that the management of distressed reactions is detailed in the resident's care plan and the reason for and outcome of any administration of medicines is recorded. **Response by registered provider detailing the actions taken:** Management Spoke with staff responsible for this incident. Social Worker informed. Management have asked for Care Plan to be updated. To include: what stage medication can be administrated, when Service User is in a distressed State.
Recommendation 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 22 October 2016	The registered provider should ensure that the management of pain is clearly referenced in a care plan for residents who are unable to verbalise pain. **Response by registered provider detailing the actions taken:** Social Worker asked if this could be included in Care Plan.

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

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