Unannounced Medicines Management Inspection Report
21 June 2018

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

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 13 beds that provides care for residents living with care needs as detailed in Section 3.0. The home is divided into two houses (Ross Lodge and Ross House) which are adjacent to each other.

3.0 Service details

Organisation/Registered Provider: Ross Lodge **Responsible Individuals:** Mrs Joyce McKinney & Mr Alex McKinney	**Registered Manager:** See box below
Person in charge at the time of inspection: Ms Karen Nelson	**Date manager registered:** Ms Karen Nelson (Acting – no application required)
Categories of care: Residential Care (RC): LD – Learning disability LD(E) – Learning disability – over 65 years PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 13 comprising: a maximum of six persons to be accommodated in Ross Lodge a maximum of seven persons to be accommodated in Ross House

4.0 Inspection summary

An unannounced inspection took place on 21 June 2018 from 09.40 to 13.20.

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, training, administration of most medicines, the general standard of record keeping and medicines storage.

Two areas for improvement were identified in relation to the administration of medicines and the completion of personal medication records.

Following discussion with two residents and observation of other residents we noted that they were relaxed and comfortable in their environment.

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	2

Details of the Quality Improvement Plan (QIP) were discussed with Ms Karen Nelson, Manager, 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.

4.2 Action/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP no further actions were required to be taken following the most recent inspection undertaken on 20 March 2018. 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 incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

A poster informing visitors to the home that an inspection was being conducted was displayed.

During the inspection the inspector met with two residents, two senior care staff, the estates manager and the manager.

Ten questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

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

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 20 March 2018

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 the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 22 September 2016

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 of Improvement 1 **Ref**: Standard 6 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that the management of distressed reactions was recorded in a care plan. These medicines had not been administered for some time. We were advised that a record of the reason and outcome would be maintained.	
Area of Improvement 2 **Ref**: Standard 6 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that when a resident was unable to communicate pain, this was referenced in a care plan.	

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 for staff. The impact of training was monitored through team meetings, supervision and annual appraisal. Refresher training in medicines management, epilepsy awareness, diabetes awareness and the administration of external preparations was provided in the last year. Other training included the management of swallowing difficulty and dementia. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to; training was provided annually.

The management of medicines for new residents, medicine changes and residents accommodated for a period of short break care was reviewed. Written confirmation of medicine regimes for new residents was received. The personal medication records were written and updated by two members of trained staff. In relation to short break care, staff advised that these were planned admissions and medicine regimes were confirmed at or immediately prior to admission. This was often verbally with the resident's family. It was suggested that staff should consider recording this confirmation. The manager advised that this would be implemented with immediate effect. Personal medication records for residents receiving short break care were written by the resident's general practitioner.

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. Newly prescribed medicines had been received into the home without delay.

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 subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. There was no stock held at the time of the inspection.

Satisfactory arrangements were observed for the management of high risk medicines e.g. warfarin and insulin. Insulin and blood monitoring was managed by the community nursing team.

Discontinued or expired medicines for residents accommodated on a permanent basis were returned to the community pharmacy for disposal. Any medicines remaining at the end of the period of short break care were returned to the resident's family.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Oxygen was held in stock. Warning signage was in place.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission 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.

Most of the sample of medicines examined had been administered in accordance with the prescriber's instructions. A few minor discrepancies were observed and discussed for close monitoring. However, for one medicine which was to be administered every three days, this did not always occur and resulted in delayed administration. We were advised that the due date for administration should be recorded in the diary. An effective system should be developed to alert staff when doses of these medicines were due for administration. An area for improvement was identified.

The management of distressed reactions, pain and swallowing difficulty were examined. The relevant care plans and medicines records were in place. See also Section 6.2.

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.

Most of the medicine records were well maintained and facilitated the audit process. However, the completion of personal medication records should be reviewed. We noted some of these required updating in relation to medicine doses and discontinued medicines. An area for improvement was identified.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for the majority of medicines. In addition, an audit was completed by the community pharmacist on a periodic basis.

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

Areas of good practice

There were some examples of good practice in relation to the completion of medicine records, care planning and the administration of medicines.

Areas for improvement

An effective system should be developed to ensure that medicines prescribed at specific time intervals are administered as prescribed.

The completion of personal medication records should be reviewed to ensure that these are fully and accurately maintained.

	Regulations	Standards
Total number of areas for improvement	0	2

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.

The administration of medicines to residents was not observed at this inspection. Following discussion with staff they advised that residents were given time to take their medicines and medicines were administered as discreetly as possible; they were knowledgeable about the residents' medicines.

We noted the warm and welcoming atmosphere in the home. The residents were observed to be content and comfortable in their environment. A number of the residents were chatting about the upcoming barbeque and music planned and how they were looking forward to the event.

We met with two residents, who expressed their satisfaction with the staff and the care provided. They advised that they were administered their medicines on time and stated they had no concerns. Comments included:

"I enjoy being here and come every month."
"They (staff) look after me; the staff are good."
"I like it here and am happy here."
"There is good food."

Throughout the inspection, it was found that there were good relationships between the staff and the residents. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was clear from discussion and observation of staff, that they were familiar with the residents' likes and dislikes.

Of the ten questionnaires which were left in the home to receive feedback from residents and their representatives, none were returned within the specified time frame (two weeks). Any comments from residents and their representatives in questionnaires received after the return date will be shared with the manager for information and action as required.

Areas of good practice

Staff listened to residents 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.

The inspector discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents. We were advised that there were arrangements in place to implement the collection of equality data in Ross Lodge/Ross House.

Written policies and procedures for the management of medicines were in place. These had been updated and were readily available for staff reference. There were systems in place to keep staff up to date of any changes. This usually occurred at the team meetings.

The management of medicine related incidents was reviewed. Staff confirmed that they knew how to identify and report incidents and advised of the procedures followed to ensure that all staff were made aware and to prevent recurrence. 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.

The governance arrangements for medicines management were examined. The manager advised of the auditing processes completed by staff and herself; and how areas for improvement were detailed in an action plan, shared with staff to address and systems to monitor improvement.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with the manager.

The staff we met with spoke positively about their work and advised there were good working relationships in the home, with relatives and with other healthcare professionals. They advised they felt well supported in their work. We were also advised that there were effective communication systems in the home to ensure that all staff were kept informed.

No online questionnaires were completed by staff within the specified time frame (two weeks).

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

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Karen Nelson, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)

Area for improvement 1 **Ref**: Standard 33 **Stated:** First time **To be completed by:** 21 July 2018	The registered person shall develop a system to ensure that medicines are administered in accordance with the prescribed time intervals. Ref: 6.5
	Response by registered person detailing the actions taken: System has been developed to ensure medicines are administered at prescribed times. Staff clearly set medication rounds on a daily basis in accordance with residing clients and their specific prescribed medication. Staff also confirm at admission with next of kin or key worker if there are any changes in medication and update kardex if necessary. Staff also ensure there is an up to date medication report from GP if there are any changes to medication.
Area for improvement 2 **Ref**: Standard 31 **Stated**: First time **To be completed by:** 21 July 2018	The registered person shall closely monitor the completion of personal medication records to ensure that these are accurate at all times. Ref: 6.5
	Response by registered person detailing the actions taken: Individual medication audits are completed for each client at time of administration. Weekly audits are carried out by senior care assistant and monthly audits by manager. Any disrepancies are noted and dealt with following policy and procedure.

Please ensure this document is completed in full and returned via the Web Portal

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