The Regulation and Quality Improvement Authority

Mantlin Court
RQIA ID: 1755
Mantlin Road
Kesh
BT93 1TU

Inspector: Helen Mulligan
Inspection ID: IN022524

Tel: 028 6863 3149
Email: gillian.ingram@westerntrust.hscni.net

Unannounced Medicines Management Inspection of Mantlin Court

22 June 2015

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
Tel: 028 8224 5828 Fax: 028 8225 2544 Web: www.rqia.org.uk

1. Summary of Inspection

An unannounced medicines management inspection took place on 22 June 2015 from 09:30 to 12:30.

Overall on the day of the inspection the management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no areas of concern. A Quality Improvement Plan (QIP) was not included in this report.

This inspection was underpinned by the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last medicines management inspection on 24 April 2012.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Western Health and Social Care Trust Ms Elaine Way CBE	**Registered Manager:** Ms Gillian Ingram
Person in Charge of the Home at the Time of Inspection: Ms Gillian Ingram	**Date Manager Registered:** 01 April 2005
Categories of Care: RC-LD, RC-LD(E)	**Number of Registered Places:** 18
Number of Residents Accommodated on Day of Inspection: 14	**Weekly Tariff at Time of Inspection:** £470.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and to determine if the following standards and themes have been met:

Standard 30: Management of medicines
Standard 31: Medicine records
Standard 33: Administration of medicines

Theme 1: Medicines prescribed on a "when required" basis for the management of distressed reactions are administered and managed appropriately.

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to the inspection, the inspector reviewed the management of incidents reported to RQIA since the previous medicines management inspection.

During the inspection the inspector met with the registered manager and a senior care worker employed in the home.

The following records were examined during the inspection:

Medicines requested and received
Personal medication records
Medicines administration records
Medicines disposed of or transferred
Controlled drug record book
Medicine audits
Policies and procedures
Care plans
Training records.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced care inspection dated 23 March 2015. No requirements or recommendations were made at this inspection.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Inspection

Last Inspection Recommendations		Validation of Compliance
Recommendation 1 **Ref**: Standard 30 **Stated once**	The registered manager should ensure that written Standard Operating Procedures are available for the management of controlled drugs.	**Met**
	Action taken as confirmed during the inspection: Standard Operating Procedures for the management of controlled drugs were in place.	
Recommendation 2 **Ref**: Standard 31 **Stated once**	The registered manager should ensure that handwritten entries on medication administration records are verified and signed by two designated members of staff.	**Met**
	Action taken as confirmed during the inspection: All handwritten entries on medication administration records had been signed by two designated members of staff.	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

A randomly selected sample of medicines was audited during the inspection. No discrepancies were noted in these audits, indicating that medicines are being administered as prescribed.

Robust systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Orders for medicines have been made in writing to the prescriber and prescriptions have been received into the home and checked against the order. A record of the transfer of prescriptions to the community pharmacist for dispensing has been maintained. This is good practice.

Records showed that discontinued and expired medicines have been returned to the community pharmacist for disposal.

There was evidence that robust arrangements are in place to ensure the safe management of medicines during a patient's admission to the home. Medication details have been confirmed with the prescriber in writing and personal medication record sheets have been completed and checked by two members of staff.

The medicines examined at the inspection were available for administration and were labelled appropriately.

Medicine records were well-maintained and facilitated the audit process.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines were in place. Records showed these had been reviewed and updated in 2014. Standard Operating Procedures for the management of controlled drugs were in place.

Records showed that medicines are managed by members of staff who have been trained and deemed competent by the registered manager. An induction process was in place. Update training on the management of medicines was completed by designated members of staff in 2014. Records showed that staff competency in the management of medicines has been reviewed on at least an annual basis.

There were robust arrangements in place to audit practices for the management of medicines. All medicines in the home were being audited each month and records of audits have been maintained and were available for inspection. In addition, some medicines, including those prescribed on a "when required" basis, laxatives and inhalers, are being monitored and audited daily. The community pharmacist complements this audit activity by performing a medicines audit each quarter. A review of the home's audit records showed that no discrepancies had been identified and members of staff are commended for this good practice.

There were procedures in place to report and learn from any medicine related incidents that have occurred in the home. Medicine related incidents, reported to RQIA since the previous medicines management inspection, have been managed appropriately.

Is Care Compassionate? (Quality of Care)

The use of anxiolytic medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed for two residents in the home. A care plan detailing the management of distressed reactions and the circumstances under which the medicine(s) is/are to be administered was in place for each resident. The parameters for administration were recorded on the residents' personal medication records. Members of staff had recorded why the "when required" medicine had been administered and had noted the outcome of the administration. A restrictive interventions monitoring plan has been completed by two members of staff on each occasion when a "when required" anxiolytic medicine has been administered. Members of staff were aware of the signs, symptoms and triggers of distressed behaviour and knew how to manage them appropriately for each individual in the home.

The management of pain was reviewed during the inspection. A care plan was in place for one resident who is prescribed pain relief on a "when required" basis. The care plan detailed the management of the patient's pain and there was evidence the care plan is reviewed on a

monthly basis. When analgesics are administered, the effect and the patient's comfort has been monitored and recorded in the majority of cases.

Areas for Improvement

During the inspection, members of staff were reminded that records of the administration of pain relief prescribed on a "when required" basis should make reference to the effect of the administration on each occasion.

The registered manager agreed that all future residents admitted to the home will have pain management reviewed as part of their admission assessment.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.4 Additional Areas Examined

Medicines were being stored safely and securely and in accordance with the manufacturers' instructions.

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Gillian Ingram	**Date Completed**	08/07/15
Registered Person	Elaine Hay	**Date Approved**	20.7.15
RQIA Inspector Assessing Response	[signature]	**Date Approved**	27/7/15

Please provide any additional comments or observations you may wish to make below:

Please complete in full and return to pharmacists@rqia.org.uk from the authorised email address

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations.