Unannounced Medicines Management Inspection Report
5 May 2017

Trench Park

Type of service: Residential Care Home
Address: 28 Trench Park, Belfast, BT11 9FG
Tel No: 028 9504 3990
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Trench Park took place on 5 May 2017 from 10.45 to 13.10.

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 patients. 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?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Care plans in relation to medicines management were in place. No requirements or recommendations were made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. There were arrangements in place to ensure medicines were administered in accordance with the resident's preferences. 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. Systems were in place to enable management to identify and cascade learning from any medicine related 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	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Jane McGowan, Registered Manager, 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.

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 22 November 2016.

2.0 Service details

Registered organisation/registered person: Belfast HSC Trust/ Mr Martin Joseph Dillon	**Registered manager:** Mrs Jane McGowan
Person in charge of the home at the time of inspection: Mr Declan McHugh until 11.00 and Mrs Jane Mc Gowan thereafter	**Date manager registered:** 29 July 2008
Categories of care: RC-LD, RC-LD(E)	**Number of registered places:** 2

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

We met with two staff and the registered manager.

Fifteen questionnaires were issued to residents, their relatives/representatives and staff, with a request that these were completed and returned within one week of 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
- 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 22 November 2016

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.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 3 July 2014

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 30 **Stated:** First time	The registered manager should further develop the policies and procedures for medicines management to ensure these include the transfer of medicines at the end of the period of respite care and standard operating procedures for controlled drugs in Trench Park.	**Met**
	Action taken as confirmed during the inspection: Medicines management policies and procedures had been updated after the last medicines management inspection to cover these areas. The most recent update was in October 2016.	
Recommendation 2 **Ref:** Standard 30 **Stated:** First time	The registered manager should ensure that care plans are in place for service users who are prescribed the administration of medicines on a 'when required' basis for the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: Care plans regarding the management of distressed reactions were in place and evaluated regularly.	

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. Arrangements were in place to monitor staff competency in medicines management. A programme of training was in place. This included refresher training in the management of medicines, epilepsy, and safeguarding.

Robust arrangements were in place for the safe management of medicines at each period of respite care. Personal medication records were usually signed by the resident's general practitioner or by two members of trained staff. Staff advised of the procedures in place to manage any changes during each period of respite care.

Appropriate arrangements were in place for administering medicines in disguised form. A care plan was maintained.

Discontinued or expired medicines were managed appropriately. Any medicines remaining at the end of each period of respite care were returned to the resident's family.

There were no residents accommodated in the home at the time of the inspection and there were no medicines held in stock. Lockable cupboards were available for the safe storage of medicines, including a medicines refrigerator for medicines which required cold storage.

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?

As there were no medicines held in stock, a sample of records completed during recent periods of respite care were used to audit medicines. With the exception of one medicine, the sample of medicines examined had been administered in accordance with the prescriber's instructions. The registered manager agreed to closely monitor this medicine and discuss with staff.

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. A care plan was in place. 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. A separate chart detailing the reason for and the outcome of the administration was maintained.

The management of pain was discussed. Staff advised that pain controlling medicines would rarely be administered. However, if pain relief was required this was discussed with the resident's relative or general practitioner. They confirmed that they were aware of how pain would be expressed by the residents and that there were procedures in place to ensure the resident was comfortable.

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 resident's relative.

Most of the medicine records were well maintained and facilitated the audit process. Staff were reminded that the quantity of liquid medicines received and transferred, should be fully recorded on each occasion.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.5 Is care compassionate?

There were no residents accommodated in the home at the time of the inspection, therefore the administration of medicines to residents was not observed.

Following discussion with staff it was evident that the residents were given time to take their medicines, in accordance with their preferences.

Staff provided examples of where some medicines were administered later in the morning, as the resident liked to stay in bed. They confirmed that they were aware of the need to adhere to the minimum time intervals for medicines prescribed more than once a day.

As part of the inspection, questionnaires were issued to residents, their relatives/ representatives and staff. Four questionnaires were received. The responses were recorded as 'very satisfied' with the management of medicines 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?

Written policies and procedures for the management of medicines were in place. These had been updated in the last year.

In relation to the regional safeguarding procedures, staff confirmed they were familiar with these and were aware of when incidents must be considered as reportable to the adult safeguarding lead. Training had been provided and further training was planned. A safeguarding file was in place and included a policy, details of the names and contact numbers for the safeguarding lead and the safeguarding team.

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 were systems to share the learning from incidents.

An auditing process for medicines management was in place. Medicines were usually audited at the end of each period of respite care. The registered manager also completed an overarching audit on a monthly basis, which included care plans specific to medicines. The registered manager advised that any identified areas for improvement were discussed with staff individually and at team meetings.

Following discussion with the registered manager and staff, it was evident that 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.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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