Unannounced Medicines Management Inspection Report
21 August 2017

2-1-2 Old Holywood Road

Type of service: Residential Care Home
Address: 212 Old Holywood Road, Holywood, BT18 9QS
Tel No: 028 9042 5554
Inspector: Helen Daly

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 nine beds that provides care for residents with a learning disability.

3.0 Service details

Organisation/Registered Provider: Cornerstone Care 212 Limited **Responsible Individual(s):** Mrs Irene McBurney	**Registered Manager:** Mrs Irene McBurney
Person in charge at the time of inspection: Mrs Irene McBurney	**Date manager registered:** 10 July 2017
Categories of care: Residential Care (RC) LD – learning disability. LD (E) – learning disability – over 65 years	**Number of registered places:** 9 The home is approved to provide care on a day basis only to one person

4.0 Inspection summary

An unannounced inspection took place on 21 August 2017 from 10.30 to 13.40.

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 medicines administration and storage.

Areas requiring improvement were identified in relation to the standard of maintenance of the personal medication records, care plans for pain and the management of controlled drugs.

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	*3

*The total number of areas for improvement includes two which have been stated for a second time.

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Irene McBurney, Registered Person, 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

The most recent inspection of the home was an unannounced care inspection undertaken on 27 June 2017. Other than those actions detailed in the QIP no further actions were required to be taken.

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 medication related incidents

During the inspection the inspector met with two care assistants, the deputy manager and the registered person.

A total of 15 questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA.

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

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
- medicines storage temperatures
- medicine audits
- 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 27 June 2017

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 3 August 2015

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 for improvement 1 **Ref:** Standard 31 **Stated:** First time	It is recommended that the registered person ensures that the areas identified for improvement on the personal medication records are addressed.	**Not Met**
	Action taken as confirmed during the inspection: The date of writing had not been recorded. Two members of staff had not verified and signed updates on the personal medication records. Obsolete personal medication records had been cancelled and archived. This area for improvement had not been met and was stated for a second time.	
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time	It is recommended that the registered person ensures that detailed care plans are in place when medicines are added to food to assist administration.	**No longer applicable**
	Action taken as confirmed during the inspection: The registered person and deputy manager advised that medicines were no longer being added to food to assist administration.	

Area for improvement 3 **Ref:** Standard 30 **Stated:** First time	It is recommended that the registered person ensures that care plans are in place for the management of pain in those residents who cannot verbalise their pain.	**Not met**
	Action taken as confirmed during the inspection: Care plans for the management of pain were not in place. The deputy manager was in the process of updating all care plans. Advice on the required details for pain management care plans was provided. This area for improvement had not been met and was stated for a second time.	

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.

The registered person confirmed that medicines were managed by staff who have been trained and deemed competent to do so. Supervisions had been completed with all senior staff. The registered person advised that update training was planned and that competencies would be re-assessed following this training. Care assistants had received training on the application of emollient preparations and management of thickening agents. Records were available for inspection.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Antibiotics and newly prescribed medicines had been received into the home without delay. It was agreed that a photocopy of all current prescriptions would be made available in the home to ensure that personal medication records accurately reflect the prescribers' most recent instructions.

The management of medication changes was reviewed and found to be unsatisfactory. Personal medication records were not up to date. Some recently prescribed medicines had not been recorded and medicines had not been discontinued by putting a line through the entry and dating. Where updates had been recorded, they had not been signed and verified by two members of staff. These findings were discussed in detail with the registered person and deputy manager. The registered person advised that a list of currently prescribed medicines would be requested from the prescribers and that all personal medication records would be re-written without delay. Due to the assurances provided, this area for improvement has been incorporated into the area for improvement regarding the standard of maintenance of the personal medication records identified in Sections 6.2 and 6.5.

The registered person advised that training on safeguarding was taking place on 22 August 2017. The trainer had been requested to include the new regional procedures.

The registered person advised that there had been no new admissions to the home since she took up her position. She confirmed that going forward, written confirmation of all medicines would be requested and that two staff would be involved in writing the personal medication records.

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 once daily. Controlled drug balances should be checked at each handover of responsibility. An area for improvement was identified.

Discontinued or expired medicines were disposed of appropriately. Two staff recorded the disposal of medicines.

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. The medicine refrigerator was checked daily; only Ensure was being stored in the refrigerator. It was agreed that an easy read thermometer would be obtained and that the room temperature would be checked daily.

Areas of good practice

Since coming into post just prior to this inspection the registered person and deputy manager had identified shortfalls in the management of medicines in the home. They had requested training and were due to implement improvements imminently. They were receptive of all advice provided by the inspector.

Areas for improvement

The registered person shall review the management of controlled drugs to ensure that balances are checked at each handover of responsibility.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The majority of medicines were supplied in weekly compliance aids; all had been administered as prescribed. The audits which were carried out on medicines not in the compliance aids were correct.

The management of pain was examined. Care plans were not in place. The registered person and deputy manager advised that not all residents could verbalise their pain but that staff were aware of how each resident expressed their pain. Recent examples of the administration of pain relief were discussed. The management of pain should be reviewed. Care plans should be in place. These care plans should detail the possible cause of the pain, the prescribed medicines and how the residents usually express their pain. An area for improvement was identified for the second time.

The management of swallowing difficulty was examined. Care plans and speech and language assessments were in place. Staff were aware of which residents were prescribed thickening agents and records of administration were maintained. The administration records included the required consistency level. It was noted that the thickening agents had not been recorded on the personal medication records (see below).

The registered person 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.

With the exception of the personal medication records, the majority of medicine records had been maintained in a satisfactory manner. The following improvements are necessary in the standard of maintenance of the personal medication records:

- the personal medication records must be up to date; all currently prescribed medicines, including thickening agents, should be listed
- discontinued medicines should be cancelled by drawing a line through the entry, dating and signing
- the date of writing should be recorded
- two staff should verify and sign the personal medication records at the time of writing and at each update

An area for improvement was identified for the second time.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for medicines which were not supplied in the weekly compliance aids.

Following discussion with the registered person and staff, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas of good practice

There were examples of good practice in relation to the administration of medicines.

Areas for improvement

It is recommended that the registered person ensures that the areas identified for improvement on the personal medication records are addressed.

It is recommended that the registered person ensures that care plans are in place for the management of pain in those residents who cannot verbalise their pain.

	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 had been completed prior to the commencement of this inspection and was not observed. Staff were knowledgeable about the administration of medicines.

Of the questionnaires that were issued, one was returned from a resident and one was returned by staff. The responses indicated that they were very satisfied / satisfied with all aspects of the care in relation to the management of medicines.

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. A birthday celebration was planned for later in the day.

Areas of good practice

Staff listened to residents and relatives 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.

Written policies and procedures for the management of medicines had recently been reviewed and updated. Plans were in place to discuss the updates with care assistants.

There were robust arrangements in place for the management of medicine related incidents; those reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

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

Following discussion with the registered person and deputy manager, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Not all of the areas for improvement identified at the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement sustained, 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 and prompt action was taken.

Areas of good practice

There were examples of good practice in relation to 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 Mrs Irene McBurney, Registered Person, 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 Web Portal for assessment by the inspector.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

Quality Improvement Plan

Action required to ensure compliance the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 31 **Stated:** Second time **To be completed by:** 21 September 2017	It is recommended that the registered person ensures that the areas identified for improvement on the personal medication records are addressed. **Response by registered person detailing the actions taken:** Personal records have been updated for all residents after receiving prescriptions from GP. Records have been checked and signed by two members of staff. Prescription sheets now include thickening agents and all up to date prescribed medication. New recording sheets have been implemented. All obsolete personal records have been cancelled with signatures of two people and filed.
Area for improvement 2 **Ref:** Standard 30 **Stated:** Second time **To be completed by:** 21 September 2017	It is recommended that the registered person ensures that care plans are in place for the management of pain in those residents who cannot verbalise their pain. **Response by registered person detailing the actions taken:** Pain care plans are now in place for all residents from 22/8/2017. These will be evaluated each month.
Area for improvement 3 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 21 September 2017	The registered person shall review the management of controlled drugs to ensure that balances are checked at each handover of responsibility. **Response by registered person detailing the actions taken:** The checking of controlled drugs at the end of each shift have been commenced from 23/8/2017. Policy has been updated to state same.

Please ensure this document is completed in full and returned via web portal

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