Unannounced Medicines Management Inspection Report
5 June 2017

24 Pettigo Road

Type of Service: Residential Care Home
Address: Letterkeen, Kesh, BT93 1QX
Tel No: 028 6863 3132
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 that provides care for residents with a learning disability, both under and over 65 years of age.

3.0 Service details

Organisation/Registered Provider: Praxis Care Group / Challenge **Responsible Individual(s):** Mr Andrew James Mayhew	**Registered Manager:** Miss Nicole West
Person in charge at the time of inspection: Mr Mark McNulty – Team Leader	**Date manager registered:** 1 March 2017
Categories of care: Residential Care (RC): LD - learning disability LD(E) - learning disability – over 65 years	**Number of registered places:** 8 LD and LD(E) with associated physical disability

4.0 Inspection summary

An unannounced inspection took place on 5 June 2017 from 10.20 to 12.25.

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).

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, medicine records 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 the residents' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr Mark McNulty, Team Leader, 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.

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 on 25 May 2017.

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

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

- 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 the team leader. The other staff on duty were busy meeting the residents' needs.

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

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

Areas for improvements 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 25 May 2017

The most recent inspection of the home was an unannounced care inspection. The report has been issued. The QIP will be reviewed by the care inspector when it is returned and will be validated at the next inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 19 May 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 30 **Stated:** First time	It is recommended that the registered person should ensure prescriptions are received by the home and checked against the order before being forwarded to the community pharmacy for dispensing.	**Met**
	Action taken as confirmed during the inspection: Prescriptions were received into the home and checked against the order before being forwarded to the community pharmacy for dispensing.	
Area for improvement 2 **Ref:** Standard 31 **Stated:** First time	It is recommended that the registered person should ensure records of the administration of thickening agents are adequately maintained.	**Met**
	Action taken as confirmed during the inspection: Thickening agents were not currently prescribed. The team leader advised that this recommendation was addressed following the last inspection. Given this assurance this area of improvement was assessed as met.	
Area for improvement 3 **Ref:** Standard 30 **Stated:** First time	It is recommended that the registered person should ensure each resident in the home has a pain assessment completed on admission to the home and pain assessment tools and care plans are in place where appropriate.	**Met**
	Action taken as confirmed during the inspection: There had been no new admissions to the home since the last medicines management inspection. Care plans for the management of pain were in place.	

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. The impact of training was monitored through the home's auditing system. Competency assessments were completed annually. Competency assessments which had been completed in March 2017 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. 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. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two members of staff. This safe practice was acknowledged.

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.

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 well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. The temperature of the medicine refrigerator and treatment room were checked daily. Satisfactory recordings were observed.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medication changes and controlled drugs.

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.

The sample of medicines examined had been administered in accordance with the prescriber's instructions.

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. Care plans were 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. The reason for administration was being recorded on the "when required" sheets. It was agreed that the outcome of administration would also be recorded.

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.

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. Areas of good practice were acknowledged. They included the additional sheets to record the reason for the administration of "when required" medicines.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several solid dosage medicines and nutritional supplements. A robust audit tool was completed by the registered manager each month. Action plans were available for inspection.

Following discussion with the team leader, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues. All residents had a review with the consultant psychiatrist at least annually. Records of the medication reviews were held on the medicines file.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 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.

We did not observe the administration of medicines to residents during the inspection. The team leader advised that medicines were administered to residents in accordance with their preferences.

Fifteen questionnaires were left in the home to facilitate feedback from residents, staff and relatives. Two were returned within the time frame from staff who advised that they were "very satisfied" with all aspects of the management of medicines.

Residents who could not verbalise their feelings in respect of their care were observed to be comfortable in their surroundings and in their interactions with staff. Staff were speaking kindly to residents.

Areas of good practice

Staff listened to patients 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 were available on the medicines file.

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 was evidence of the action taken and learning implemented following incidents. 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.

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 team leader, 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. They advised that any resultant action was communicated with staff at handovers or via team meetings.

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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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.

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