Unannounced Post-Registration Medicines Management Inspection Report
21 January 2019

Madelayne Court

Type of Service: Residential Care Home
Address: Downhill Suite, 1-27 Nursery Avenue, Portstewart, BT55 7LG
Tel No: 028 7083 1014
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 provider 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 up to 18 residents living with old age and not falling within any other category. The home is in a shared complex with a registered nursing home.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Mr Gavin O'Hare – Connolly	**Registered Manager:** Mrs Mabel Cole
Person in charge at the time of inspection: Mrs Mabel Cole	**Date manager registered:** 11 June 2018
Categories of care: Residential Care (RC) I – Old age not falling within any other category	**Number of registered places:** 18 This includes the provision of care on a day basis for one person.

4.0 Inspection summary

An unannounced inspection took place on 21 January 2019 from 10.50 to 14.15.

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 pre-registration care 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 governance, training and competency assessment, medicines administration, the completion of most medicine records, care planning and the management of controlled drugs.

Areas for improvement were identified in relation to the cold storage of medicines, the management of bisphosphonate medicines and the completion of personal medication records.

The residents and relative we met with spoke positively about the staff and the care provided. There was a warm and welcoming atmosphere in the home and the residents were observed to be 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	3

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Mabel Cole, Registered Manager and two other senior members of staff, 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 pre-registration inspection

The most recent inspection of the home was an announced care inspection undertaken on 24 May 2018. Other than the action 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 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 home registered

A poster was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

During the inspection we met with two residents, one relative, the unit manager, the deputy manager and the registered manager.

We provided 10 questionnaires to distribute to residents and their representatives, for completion and return to RQIA and we asked the registered manager to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

A sample of the following records was examined during the inspection:

- medicines received
- personal medication records
- medicine administration records
- medicines disposed of
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

We left ‘Have we missed you?’ cards in the home to inform residents and their representatives, who we did not meet with or were not present in the home, how to contact

RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

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 24 May 2018

The most recent inspection of the home was an announced care inspection. The completed was approved by the care inspector and will be validated at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection

This was the first medicines management inspection to the home.

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. Staff competency assessments were completed following induction, at least annually or more frequently as required. The impact of training was monitored through team meetings, supervision and annual appraisal. A sample of training and competency records was provided.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and for the management of medicine changes. Written confirmation of medicine regimes and any medicine changes were obtained. Personal medication records were updated by two trained staff. This is safe practice and was acknowledged.

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, report and follow up any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed.

The management of controlled drugs was reviewed. 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. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were in place for the management of high risk medicines e.g. warfarin and insulin. Care plans were maintained. We were advised that all relevant staff were familiar with the signs and symptoms of hyperglycaemia and hypoglycaemia and how to manage changes in blood sugar levels.

The procedures for the disposal of medicines were reviewed. The registered manager was advised that medicines do not have to be managed as clinical waste/uplifted by a waste management company in residential care homes. It was agreed that medicines for disposal, including controlled drugs, would be returned to the community pharmacy from the day of the inspection onwards.

Medicines were being stored safely and securely and in accordance with the manufacturer's instructions. There were satisfactory systems in place to manage medicines with a limited shelf life, once opened. In relation to cold storage, we noted that there was a build-up of ice in the medicines refrigerator; staff stated this had been identified and was to be addressed. The same minimum and maximum refrigerator temperatures were being recorded every day, with maximum temperatures above the accepted upper limit of 8^{o}C. Staff were advised that the refrigerator temperatures should be maintained between 2^{o}C and 8^{o}C and the refrigerator thermometer should be reset on a daily basis. An area for improvement was identified.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staff training, competency assessments, the management of medicines changes and controlled drugs.

Areas for improvement

The cold storage of medicines should be reviewed and revised.

	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

A new medicine system had been introduced in recent months; staff advised that this was working well. The sample of medicines examined had been administered in accordance with the prescriber's instructions.

Community nurses were responsible for the administration of injectable medicines. This was clearly referenced in the residents' care plans.

There were arrangements in place to alert staff of when doses of weekly medicines were due. However, in relation to bisphosphonate medicines, these were not always administered separately from other medicines, in accordance with the manufacturers' instructions. An area for improvement was identified.

The management of pain and distressed reactions was examined. The medicines were recorded on the personal medication record. Specific protocols regarding administration and care plans were maintained. 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 system was in place to record the reason for and outcome of the administration.

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. Areas of good practice included the separate administration records for transdermal patches and high risk medicines. In relation to the completion of personal medication records the date of writing and full details regarding the minimum frequency intervals for "when required" medicines should be recorded. An area for improvement was identified.

A few medicines were self-administered by the residents. A risk assessment was not in place for two residents. We were advised that these residents had been deemed competent and staff monitored compliance. It was agreed that these risk assessments and the relevant care plans would be developed immediately after the inspection.

Practices for the management of medicines were audited throughout the month by staff and management. A quarterly audit was completed by the community pharmacist.

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

Areas of good practice

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

Areas for improvement

The necessary arrangements must be made to ensure that bisphosphonate medicines are administered in accordance with the manufacturers' instructions.

The completion of personal medication records should be closely monitored to ensure all relevant information is recorded.

	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 during the inspection. Following discussion with staff it was evident they were knowledgeable about the residents' medicines.

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

We noted the warm and welcoming atmosphere in the home. We met with two residents and one relative; they spoke positively about the staff and the care provided. Comments included:

"The staff are very good; I've no complaints."
"I'm happy and have settled in well."
"Everything is ok; I get on ok."

Of the questionnaires which were left in the home to facilitate feedback from residents and their representatives, none were returned within the time frame (two weeks). Any comments in questionnaires received after the return date will be shared with the registered manager as necessary.

Areas of good practice

There was evidence that 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

We 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. Arrangements were in place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. A small number of these were spot checked at the inspection. Staff confirmed that there were procedures in place to ensure that they were made aware of any changes.

There were satisfactory arrangements in place for the management of medicine related incidents. Staff knew how to identify and report incidents, and provided details of the procedures in place to ensure that all staff were made aware of incidents and to prevent recurrence.

The governance arrangements for medicines management were examined. We were advised of the auditing processes completed and how areas for improvement were shared with staff to address and systems to monitor improvement. A sample of audit records and details of any corrective action taken was observed.

We were advised that there were effective communication systems to ensure that all staff were kept up to date.

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 were raised with the registered manager.

The staff we met with spoke positively about their work and advised there were good working relationships in the home and with other healthcare professionals. They were complimentary regarding the management team and the training provided.

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

Areas of good practice

There were examples of good practice found throughout the inspection 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 Mrs Mabel Cole, Registered Manager and other members of the management team, 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.

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 32 **Stated:** First time **To be completed by:** 21 February 2019	The registered person shall review the cold storage of medicines to ensure temperatures are maintained between 2^{o}C and 8^{o}C. Ref: 6.4
	Response by registered person detailing the actions taken: nimda
Area for improvement 2 **Ref**: Standard 33 **Stated:** First time **To be completed by:** 21 February 2019	The registered person shall closely monitor the administration of bisphosphonate medicines to ensure these are administered in accordance with the manufacturers' instructions. Ref: 6.5
	Response by registered person detailing the actions taken: Bisphosphonate medicines are now in separate pil pak with clear instructions.
Area for improvement 3 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 21 February 2019	The registered person shall ensure that personal medication records are fully maintained. Ref: 6.5
	Response by registered person detailing the actions taken: personal medication records have date of writing, signed by 2 staff members and minimum frequency is recorded

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

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