Unannounced Medicines Management Inspection Report
14 August 2018

Northwick House

Type of service: Residential Care Home
Address: 1 Aghalun Road, Brookeborough, BT94 4EY
Tel No: 028 8953 1630
Inspector: Paul Nixon

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 15 beds that provides care for residents with a variety of care needs, as detailed in section 3.0

3.0 Service details

Registered organisation: Northwick House **Registered persons:** Mrs Carole Helena Johnston Mrs Dorothy Elizabeth Hannah Johnston	**Registered manager:** Mrs Carole Helena Johnston
Person in charge of the home at the time of inspection: Mrs Dorothy Johnston	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE – Dementia LD - Learning Disability LD (E) – Learning disability – over 65 years PH - Physical disability other than sensory impairment PH (E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 15, including a maximum of five residents in category RC-DE and a maximum of two residents in categories RC-LD or RC-LD (E)

4.0 Inspection summary

An unannounced inspection took place on 14 August 2018 from 09.50 to 12.25.

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, medicine records, medicine storage and the management of controlled drugs.

No areas for improvement were identified.

There was a warm and welcoming atmosphere in the home. Residents were relaxed and good relationships with staff were evident. They spoke positively about the care provided in the home. They were complimentary about the staff and management.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Dorothy Johnston, Registered Person, 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 two day inspection which commenced on 25 July 2018. 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 incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

During the inspection, the inspector met with four residents, two resident's representatives, one visiting healthcare professional, one of the registered persons and one member of care staff.

A total of 10 questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA.

At the request of the inspector, the person-in-charge was asked to display a poster in the home which invited staff to share their views of the home by completing an online questionnaire.

The inspector left "Have we missed you?" cards. The cards facilitate residents or their representatives who were not present at the time of the inspection to give feedback to RQIA on the quality of care provided. Flyers which gave information on raising a concern were also left in the home.

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
- care plans
- training records
- medicines storage temperatures

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 completed on 26 July 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be reviewed 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 19 May 2016

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 8 **Stated:** First time	The reason for and the outcome of administration of medicines prescribed for administration on a "when required" basis for the management of distressed reactions should be routinely recorded.	**Met**
	Action taken as confirmed during the inspection: The records of two residents who were prescribed medication for administration on a "when required" basis for the management of distressed reactions were examined. The reason for and the outcome of administration were routinely recorded.	

Area for improvement 2 **Ref**: Standard 6 **Stated:** First time	Where residents are prescribed medicines to manage pain, this should be recorded in the care plan.	**Met**
	Action taken as confirmed during the inspection: The records of two residents who were prescribed medication for the treatment of chronic pain were examined. In each instance, a care plan was 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. An induction process was in place for care staff who had been delegated medicine related tasks. The impact of training was monitored through supervision and appraisal. Competency assessments were completed annually.

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. Antibiotics and newly prescribed medicines had been received into the home without delay.

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

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

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and discharge from the home.

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 observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Injections were administered by the community nurses and records of administration, including the next due date of administration, were maintained.

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 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 at regular intervals.

Areas of good practice

There were examples of good practice in relation to the management of medicines on admission, the management of controlled drugs and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 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. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of medicines prescribed to be administered at atypical intervals were due.

Appropriate arrangements were in place for the management of distressed reactions, pain and swallowing difficulty. The details of prescribed medicines were recorded on the personal medication records, administration was appropriately recorded and care plans were in place.

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.

Practices for the management of medicines were audited throughout the month by the staff and management. The dates of opening were routinely recorded on medicine containers in order to facilitate audit activity; this good practice was recognised.

Following discussion with the registered person and staff, it was evident that other healthcare professionals are contacted when required to meet the needs of residents. Staff advised that they had good working relationships with healthcare professionals involved in resident care.

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.

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Staff were noted to be friendly, courteous and happy in their work; they treated the residents with dignity.

The residents we spoke with advised that they were very satisfied with the care provided in the home. They were very complimentary regarding staff and management. Comments made included:

- "I am more than well cared for."
- "(This home has) one of the best staff teams."
- "Couldn't be any better; staff are very good in here."
- "I am very happy here; the care is excellent; the food is great."
- "I am cared for very well."

The resident's representatives we spoke to stated that they were very pleased with the placement and that their relative had improved since coming to Northwick House; she was a different person within a month. They also stated there was good communication with management.

Of the questionnaires that were issued, one was returned from a relative. The response indicated that they were very satisfied with all aspects of the care. They commented:

- "Having local staff who know the area and the residents is a real advantage. I feel it might be beneficial to have Christian names on uniforms and casual wear."

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.

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 are in place to implement the collection of equality data in Northwick House.

Written policies and procedures for the management of medicines were in place. These were not examined in detail. Following discussion with staff it was evident that they were knowledgeable regarding the policies and procedures and that any updates were highlighted to them.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report 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 internal audit records indicated that good outcomes had been achieved.

Following discussion with the registered person and care staff, it was evident that staff knew 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 management were open and approachable and willing to listen.

No members of staff shared their views by completing an online questionnaire.

Areas of good practice

There were examples of good practice in relation to governance arrangements. 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.

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