



The **Regulation** and
Quality Improvement
Authority

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**Unannounced Medicines Management Inspection
of
Anniscliff House**

27 July 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced medicines management inspection took place on 23 July 2015 from 09.50 to 12.45.

Overall on the day of the inspection the management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no significant areas of concern though one area for improvement was identified and is set out in the quality improvement plan (QIP) within this report.

This inspection was underpinned by the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last medicines management inspection on 17 April 2012.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

The details of the QIP within this report were discussed with Mrs Bernadette McGilligan, Registered Manager as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Anniscliff Mrs Bernadette McGilligan Mrs J Davies	Registered Manager: Mrs Bernadette McGilligan
Person in Charge of the Home at the Time of Inspection: Mrs Bernadette McGilligan	Date Manager Registered: 1 April 2005
Categories of Care: RC-MP, RC-LD(E), RC-DE, RC-I, RC-MP(E)	Number of Registered Places: 17
Number of Residents Accommodated on Day of Inspection: 13	Weekly Tariff at Time of Inspection: £470

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and to determine if the following standards and themes have been met:

Standard 30: Management of medicines

Standard 31: Medicine records

Standard 33: Administration of medicines

Theme 1: Medicines prescribed on a “when required” basis for the management of distressed reactions are administered and managed appropriately.

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

Prior to the inspection, the inspector reviewed the management of incidents reported to RQIA since the previous medicines management inspection.

During the inspection the inspector met with Mrs Bernadette McGilligan, Registered Manager.

The following records were examined during the inspection:

- Medicines requested and received
- Personal medication records
- Medicines administration records
- Medicines disposed of or transferred
- Controlled drug record book
- Medicine audits
- Policies and procedures
- Care plans
- Training records.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an enforcement monitoring (Failure To Comply) care inspection dated 10 April 2015. The home was evidenced to have fully complied with the requirements of the Failure to Comply Notice.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Inspection

Last Inspection Statutory Requirement		Validation of Compliance
Requirement 1 Ref: Regulation 13 (4) Stated: Second time	Personal medication records must be fully maintained.	Met
	Action taken as confirmed during the inspection: The personal medication records were observed to have been accurately maintained.	
Requirement 2 Ref: Regulation 13 (4) Stated: First time	The registered manager must put robust arrangements in place to ensure that all medicines are available for administration as prescribed.	Met
	Action taken as confirmed during the inspection: All medicines checked were in stock.	

<p>Requirement 3</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p>	<p>The registered manager must put robust arrangements in place for staff to report any ongoing non-administration of medicines to the registered manager and prescriber.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>The registered manager confirmed that robust arrangements were in place for staff to report any ongoing non-administration of medicines to her and the prescriber. One resident had a care plan relating to their refusal to take medication on occasion.</p>		
<p>Requirement 4</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p>	<p>The registered manager must put robust arrangements in place for the management of warfarin.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>No residents were currently prescribed warfarin. However, the registered manager confirmed that, when a resident is prescribed warfarin, the dosage directions from the GP practice are kept with the personal medication record sheet and running stock balances are maintained. She stated there had been no incidents relating to the administrations of warfarin.</p>		
<p>Requirement 5</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p>	<p>The registered manager must increase the frequency of audits on all medicines; any further discrepancies must be investigated and reported to RQIA.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>Recorded evidence was provided to confirm that weekly medication audits had been performed.</p>		
<p>Requirement 6</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p>	<p>The registered manager must review the records for one resident to ensure a care plan, protocol and policy regarding rectal diazepam are in place.</p>	<p>Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>A care plan, protocol and policy regarding rectal diazepam were in place for the one resident who was prescribed this medicine.</p>		
<p>Requirement 7</p>	<p>The registered manager must ensure one</p>	<p>Met</p>

<p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p>	<p>resident's care plan is updated to reflect the management of the administration of medicines in disguised form.</p>	
	<p>Action taken as confirmed during the inspection:</p> <p>The registered manager confirmed that the care plan, which had been highlighted during the previous medicines management inspection, had been updated to reflect the management of the administration of medicines in disguised form. No residents currently have medication administered in disguised form.</p>	
<p>Last Inspection Recommendation</p>		<p>Validation of Compliance</p>
<p>Recommendation 1</p> <p>Ref: Standard 30</p> <p>Stated: First time</p>	<p>The registered manager should develop Standard Operating Procedures for controlled drugs.</p>	<p>Met</p>
	<p>Action taken as confirmed during the inspection:</p> <p>Standard Operating Procedures for the management of controlled drugs had been developed.</p>	
<p>Recommendation 2</p> <p>Ref: Standard 30</p> <p>Stated: First time</p>	<p>The registered manager should ensure when personal medication records are not verified and signed by the prescriber, a copy of the most recent prescription is kept in the home, and replaced when any changes are made.</p>	<p>Met</p>
	<p>Action taken as confirmed during the inspection:</p> <p>The registered manager confirmed that a copy of each resident's most recent prescription is kept in the home, and replaced when any changes are made.</p>	

<p>Recommendation 3</p> <p>Ref: Standard 30</p> <p>Stated: First time</p>	<p>The registered manager should include the maintenance of personal medication records in the home's auditing process.</p>	<p style="text-align: center;">Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>The registered manager confirmed that the maintenance of personal medication records is included in the home's auditing process. These records were observed to have been accurately maintained.</p>		
<p>Recommendation 4</p> <p>Ref: Standard 31</p> <p>Stated: First time</p>	<p>The registered manager should review the printed times on administration records to ensure these reflect the actual time of administration.</p>	<p style="text-align: center;">Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>The printed times on administration records had been reviewed to ensure these reflect the actual time of administration.</p>		
<p>Recommendation 5</p> <p>Ref: Standard 31</p> <p>Stated: First time</p>	<p>The registered manager should closely monitor the disposal of medicines records to ensure the date of transfer and strength of each medicine is recorded.</p>	<p style="text-align: center;">Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>The disposal of medicines record had been maintained in a satisfactory manner.</p>		

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

Medicines were being administered in accordance with the prescribers' instructions. The audit trails performed on a variety of randomly selected medicines at the inspection provided broadly satisfactory outcomes.

Arrangements were in place to ensure the safe management of medicines during a resident's admission to the home. Medication details were confirmed with the prescriber and personal medication record sheets were completed and checked by two staff members.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies are available and to prevent wastage.

All of the medicines examined at the inspection were available for administration and were labelled appropriately. Medicines were being administered only to the resident for whom they were prescribed.

The medicine records had been maintained in a satisfactory manner. Records of the ordering, receipt, administration, non-administration and disposal of medicines were maintained. Where transcribing of medicine details occurs, this process involves two members of staff to ensure the accuracy of the record.

Medicines which were discontinued or were unsuitable for use had been returned to the community pharmacy for disposal.

Satisfactory arrangements were in place for the management of controlled drugs.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines were in place.

Medicines were being managed by staff who have been trained and deemed competent to do so. An induction process is in place. The impact of training is monitored through supervision and appraisal. Training in medicines management is provided annually through the community pharmacist, who had also recently provided staff with refresher training in the administration of rectal diazepam rescue medication. Staff competency assessments are completed annually by the registered manager. The competency assessments checked were up to date.

Medication audits were being performed each week, using the dates of opening of medicine containers as the base levels for this activity. The registered manager stated that she checks the outcomes of this audit activity. A review of the audit records indicated that satisfactory outcomes had been achieved. The audit process is facilitated by the good practice of recording the date and time of opening on the medicine container.

There were procedures in place to identify, record, report, analyse and learn from any medicine related incidents that have occurred in the home.

Is Care Compassionate? (Quality of Care)

The records pertaining to a sample of residents, who were prescribed medication for administration on a "when required" basis for the management of distressed reactions, were observed at the inspection. The care plans did not detail the circumstances under which the medicines were to be administered. The parameters for administration were recorded on the personal medication records. The medicines had been infrequently administered.

The records relating to a sample of residents who were prescribed medicines for the management of pain were reviewed. Medicines which were prescribed to treat or prevent pain were recorded on the personal medication records. Examination of the administration of these medicines indicated that they had been administered as prescribed. The registered manager stated that all residents are able to communicate when they are in pain. Also, from discussion with the registered manager, it was evident that staff were aware of the signs, symptoms and triggers of pain in residents and that ongoing monitoring is necessary to ensure the pain is well controlled and the resident was comfortable.

An epilepsy management plan was in place for one resident who was prescribed rescue medication for the treatment of epileptic seizures

Areas for Improvement

Care plans should be developed for residents who are prescribed medication for administration on a “when required” basis for the management of distressed reactions. A recommendation was made.

The registered manager agreed to ensure that the removals of lidocaine patches are recorded.

The registered manager agreed to ensure that only current personal medication record sheets are kept in the medicine kardex file.

Number of Requirements:	0	Number of Recommendations:	1
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6. Quality Improvement Plan

The issue identified during this inspection is detailed in the QIP. Details of this QIP were discussed with Mrs Bernadette McGilligan, Registered Manager as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained 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 your premises. 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Residential Care Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Person/Registered Manager

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to pharmacists@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Recommendations

Recommendation 1 Ref: Standard 30 Stated: First time To be Completed by: 26 August 2015	<p>It is recommended that care plans should be developed for residents who are prescribed medication for administration on a “when required” basis for the management of distressed reactions.</p> <p>Response by Registered Person(s) Detailing the Actions Taken: Careplans have been developed for residents who are perscribed medication for administration on a "when required" basis for the management of distressed reactions.</p>
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Registered Manager Completing QIP	Bernadette Mc Gilligan	Date Completed	17/8/15
Registered Person Approving QIP	Bernadette Mc Gilligan	Date Approved	17/8/15
RQIA Inspector Assessing Response	Paul W. Nixon	Date Approved	18/8/15

Please ensure the QIP is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address