Unannounced Medicines Management Inspection Report
25 April 2017

Rocky Acres

Type of service: Residential Care Home
Address: 8 Portavogie Road, Ballyhalbert, BT22 1BU
Tel No: 028 4275 8715
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of Rocky Acres took place on 25 April 2017 from 10.45 to 12.30.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence that the management of medicines generally supported the delivery of safe care and positive outcomes for residents. Staff administering medicines were trained and competent. Two areas for improvement were identified in relation to the completion of personal medication records and the admission process for new residents. Two requirements were made, one of which has been stated for the second time and one recommendation has been stated for the second time.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure residents were receiving their medicines as prescribed. There were no areas for improvement identified.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for residents. There were no areas for improvement identified.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and share learning from any medicine audit activity. There were no areas for improvement identified.

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).

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	2	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Ms Margaret Cully, 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.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 7 December 2016.

2.0 Service details

Registered organisation/registered person: Rocky Acres Ms Margaret Cully Ms Jean Cully	**Registered manager:** Ms Margaret Cully
Person in charge of the home at the time of inspection: Ms Margaret Cully	**Date manager registered:** 1 April 2005
Categories of care: RC-DE, RC-I	**Number of registered places:** 13

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home

Prior to the inspection, it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with one care assistant and the registered person.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

Fifteen questionnaires were provided for completion by residents, residents' relatives and staff with a request that they were returned within one week of the inspection.

A sample of the following records was examined:

- 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

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 December 2016

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 their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 24 April 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person must ensure that bisphosphonates are administered in accordance with the manufacturers' instructions.	**Met**
	Action taken as confirmed during the inspection: Bisphosphonates had been administered in accordance with the manufacturers' instructions.	
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person must ensure that the personal medication record sheets are completed with all necessary information. The format of the personal medication record sheet must facilitate the recording of this information.	**Partially met**
	Action taken as confirmed during the inspection: Some further improvements are required in the completion of personal medication records as discussed in the report, and this part of the requirement has been restated. The format of the personal medication record had been reviewed and revised to facilitate the recording of all of the required information. **The first part of this requirement has been stated for a second time.**	

Requirement 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered person must ensure that a record is made of the assistance provided by staff to a resident when self-administering medication.	**Met**
	Action taken as confirmed during the inspection: None of the residents self-administer medicines; however staff were aware of the records that would be necessary.	
Requirement 4 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person must ensure that the controlled drug cabinet is fixed to a wall of solid construction with rag or rawl bolts.	**Met**
	Action taken as confirmed during the inspection: The controlled drugs cabinet was appropriately secured.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 30 **Stated:** First time	The registered person should ensure that there are comprehensive policies and procedures for the management of medicines.	**Met**
	Action taken as confirmed during the inspection: Policies and procedures for the management of medicines were in place.	
Recommendation 2 **Ref:** Standard 30 **Stated:** First time	The registered person should ensure that Standard Operating Procedures for the management of controlled drugs are developed.	**Not met**
	Action taken as confirmed during the inspection: There have been no controlled drugs in use in the home. The registered person advised that should controlled drugs be prescribed for any resident that Standard Operating Procedures would be developed at that time. The registered person was aware of how to manage controlled drugs appropriately. Given this assurance, this recommendation has not been restated.	

Recommendation 3 **Ref:** Standard 31 **Stated:** First time	The registered person should ensure that, in the absence of the prescriber's signature, handwritten entries on the personal medication record sheets are verified and signed by two staff members.	**Not met**
	Action taken as confirmed during the inspection: This had not been completed. Further guidance was given to the registered person during this inspection. **This recommendation was stated for a second time.**	
Recommendation 4 **Ref:** Standard 31 **Stated:** First time	The registered person should ensure that the disposal of medicines record is signed by the staff member returning medicines to the community pharmacy.	**Met**
	Action taken as confirmed during the inspection: The disposal of medicines record had been completed appropriately.	

4.3 Is care safe?

The registered person works closely with staff on a daily basis. Staff who administer medicines have been employed for many years and are trained and competent.

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.

The arrangements in place to manage changes to prescribed medicines must be reviewed. It was noted that these records had not been signed and updates had not been recorded until several days after they were directed by the general practitioner. Personal medication records should be updated by two members of staff in a timely manner. This was discussed with the registered person and further guidance was given. Part of the requirement made previously has been stated for a second time and the recommendation made previously has been stated for a second time.

The procedures in place to ensure the safe management of medicines during a resident's admission to the home must be reviewed. It was noted that a copy of the currently prescribed medicines had not been obtained from the general practitioner for one recently admitted resident and a record of the administration of medicines had not been made. A requirement was made.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin.

Discontinued or expired medicines were disposed of appropriately.
Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Staff were reminded of the storage requirements for some eye preparations. 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. Medicine refrigerators were checked at regular intervals.

The storage of prescriptions was found to be appropriate.

Areas for improvement

The registered person must ensure that the personal medication record sheets are completed with all necessary information. This part of the requirement made previously has been stated for a second time.

The registered person should ensure that, in the absence of the prescriber's signature, handwritten entries on the personal medication record sheets are verified and signed by two staff members. The recommendation made previously has been stated for a second time.

The registered person must ensure that the procedures in place to ensure the safe management of medicines during a resident's admission to the home are reviewed. A requirement has been made.

Number of requirements	2	**Number of recommendations**	1

4.4 Is care effective?

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 weekly, monthly or three monthly medicines were due.

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 generally well maintained and facilitated the audit process. Areas of good practice were acknowledged.

Practices for the management of medicines were audited throughout the month by the staff and management. This included maintaining running stock balances for medicines.

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.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.5 Is care compassionate?

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Residents were treated courteously, with dignity and respect. Good relationships were evident.

The administration of medicines was not observed during this inspection; however staff were very aware of the residents' needs and preferences.

None of the questionnaires that were issued during the inspection were returned within the specified timeframe for inclusion in this report.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

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

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. There had been no medicine related incidents since the last medicines management inspection.

A review of the audit records indicated that satisfactory outcomes had been achieved.

The registered person was the adult safeguarding lead. Staff knew that medicine incidents should be considered under safeguarding procedures and how to report these.

Following discussion with the registered person and care staff, 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.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Margaret Cully, Registered Person, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 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 provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to via web portal for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref:** Regulation 13 (4) **Stated:** Second time **To be completed by:** 25 May 2017	The registered person must ensure that the personal medication record sheets are completed with all necessary information.
	Response by registered provider detailing the actions taken: The medication record for the one new Resident is now completed with all necessary information included
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 25 May 2017	The registered person must ensure that the procedures in place to ensure the safe management of medicines during a resident's admission to the home are reviewed.
	Response by registered provider detailing the actions taken: The procedures are now updated and completed
Recommendations	
Recommendation 1 **Ref:** Standard 31 **Stated:** Second time **To be completed by:** 25 May 2017	The registered person should ensure that, in the absence of the prescriber's signature, handwritten entries on the personal medication record sheets are verified and signed by two staff members.
	Response by registered provider detailing the actions taken: We are now clear as to what the instruction meant and are signing all records as required

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