Inspection Report
17 November 2020

River House

Type of Home: Residential Care Home
Address: 114 Milltown Road, Belfast, BT8 7XP
Tel No: 028 9064 8314
Inspector: Catherine Glover

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 this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a residential care home which is registered to provide care for up to eight residents.

2.0 Service details

Organisation/Registered Provider: Amore (Watton) Limited **Responsible Individual:** Mrs Nicola Cooper	**Registered Manager and date registered:** Mr Lee Bratchley-Clark Acting – No Application Required
Person in charge at the time of inspection: Mr Lee Bratchley-Clark	**Number of registered places:** 8
Categories of care: Residential Care (RC): LD – learning disability LD(E) – learning disability – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 8

3.0 Inspection focus

This unannounced inspection was completed by a pharmacist inspector on 17 November 2020 from 10.30 to 13.00.

This inspection focused on medicines management within the home.

Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last care inspection would be followed up at the next care inspection.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drug records
- care plans related to medicines management
- governance and audit
- staff training and competency records

4.0 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 Lee Bratchley-Clark, Manager and Ms Tracy Henry, Regional Manager, 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.

5.0 What has this home done to meet any areas for improvement identified at the last care inspection (19 October 2020) and last medicines management inspection (11 March 2020)?

Areas for improvement were identified at the last care inspection and resulted in two Failure to Comply Notices being issued. The date for compliance on the notices is 4 January 2021 and this will be followed up by the care inspector. The report relating to the care inspection had not yet been issued at the time of this inspection.

No areas for improvement were identified at the last medicines management inspection.

6.0 Inspection Findings

6.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times residents' needs will change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, the pharmacist or during a hospital admission.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. These are records used to list all the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they are written and updated to provide a double check that they are accurate.

Copies of residents' prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription. This is good practice.

All residents should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets, self-administration etc.

Residents will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the resident's distress and if the prescribed medicine is effective for the resident.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. 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. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available in the medicines file. Records of administration were clearly recorded. The reason for and outcome of administration were recorded in the daily progress notes and on incident report forms.

6.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the resident's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

The records inspected showed that medicines were available for administration when residents required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each resident could be easily located. A controlled drugs cabinet was available for use as needed. Although the storage was secure, the controlled drugs cabinet had not been attached to a solid wall. The manager confirmed by email following the inspection that this had been rectified.

6.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to residents to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs, when medicines are administered to a resident. A sample of these records was reviewed and had been completed fully and accurately. The completed records were filed once completed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs are recorded in a controlled drug record book. These records had been fully completed.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

The audits completed during this inspection showed that medicines had been given as prescribed.

6.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how

information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

We reviewed the management of medicines for a resident who had a hospital stay and was discharged back to this home. Hospital discharge letters had been received and a copy had been forwarded to the resident's GP. The resident's personal medication records had been updated to reflect medication changes which had been initiated during the hospital stay. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

6.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident.

The audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

6.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. The manager advised that agency staff do not usually administer medicines in the home. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

Records of staff training in relation to medicines management, epilepsy awareness and the administration of buccal midazolam were available for inspection. The manager advised that all staff that administer medicines would have completed refresher training in the management of medicines by the end of November 2020. Staff who do not usually have responsibility for administering medicines had received some further training in the administration of "when required" medicines specifically for one resident. This ensured that there were sufficienct staff trained to accompany the resident on day trips.

7.0 Evaluation of Inspection

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

The outcome of this inspection concluded that that the residents were being administered their medicines as prescribed by their GP. It was evident that the management and staff have focussed on improving the systems in place for the management of medicines and therefore no areas for improvement were identified.

We would like to thank the residents and staff for their assistance throughout the inspection.

8.0 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.

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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