Inspection Report
8 December 2020

Oakmont Lodge Care Home Residential Unit

Type of service: Residential Care Home
Address: 267- 271 Old Belfast Road, Bangor, BT19 1LU
Tel No: 028 9146 5822
Inspector: Helen Daly

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 39 residents with a range of care needs as detailed in Section 2.0.

2.0 Service details

Organisation/Registered Provider: Dunluce Healthcare Bangor Ltd **Responsible Individual:** Mr Ryan Smith	**Registered Manager and date registered:** Mrs Annette Martin, Acting, no application required
Person in charge at the time of inspection: Mrs Annette Martin	**Number of registered places:** 39 There shall be a maximum of 12 residents in Category RC-DE.
Categories of care: Residential Care (RC) I – old age not falling within any other category DE – dementia	**Total number of residents in the residential care home on the day of this inspection:** 37

3.0 Inspection focus

This unannounced inspection was undertaken by a pharmacist inspector on 8 December 2020 from 10.15 to 15.10. This inspection focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified at or since the last care and medicines management inspections.
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

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	1	0

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Annette Martin, Manager, 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.

5.0 What has this home done to meet any areas for improvement identified at the last medicines management inspection (17 January 2020) and the pre-registration care and estates inspection (22 September 2020)?

No areas for improvement were identified at the pre-registration care and estates inspection.

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** Second time	The registered person shall review and revise the management of warfarin as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: We reviewed the management of warfarin for three residents. Dosage directions were received in writing for two residents. For the third resident two trained members of staff listened to the telephoned directions in order to minimise the risk of an error. Each administration was witnessed by a second member of trained staff and daily stock counts were maintained. The audits completed at the inspection indicated that warfarin had been administered as prescribed.	

6.0 What people told us about this home?

Residents were observed to be relaxing in the lounge enjoying a Christmas movie during the inspection.

We spoke with one resident who said “It is a great home; the staff and food could not be better.”

Staff were warm and friendly and it was evident from their interactions that they knew the residents well.

We met with two senior carers, the manager and the registered person. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after residents and meet their needs.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no questionnaires had been received by RQIA.

7.0 Inspection Findings

7.1 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 a GP, a pharmacist or during a hospital admission.

Residents in the home were registered with local GPs 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 were written and updated to provide a double check that they were accurate. We found that some obsolete personal medication records had not been cancelled and archived. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. The manager advised, via email, that this had been actioned immediately following the inspection and would be closely monitored. There was evidence that medicines were administered in accordance with the most recent directions.

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, 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 for two residents. 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.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required.

7.2 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.

For two residents we observed recently discontinued medicines available on the medicine trolley. The medicines had not been administered. However, this could lead to a discontinued medicine being administered in error. Discontinued medicines should be removed from the medicines trolley and stock without delay. An area for improvement was identified.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. However, the medicines room was cluttered with a weighing chair and medicines which were awaiting return to the community pharmacy for disposal. The manager advised that the community pharmacy were unable to accept returns during the pandemic. The manager contacted RQIA following the inspection. The weighing chair and medicines for return had been moved to a locked room and the community pharmacist had been contacted to ascertain if the medicines could be returned following a period of quarantine.

Two controlled drug cabinets and two medicine refrigerators were available. It was noted that the temperature of one refrigerator was not monitored. This refrigerator was used only for storing food supplements to ensure that they were palatable for residents. It was agreed that the temperature would be monitored from the date of the inspection onwards.

The manager and senior carers were reminded that in-use insulin should be marked with the date of opening and stored at room temperature and, fludrocortisone tablets should be stored in a refrigerator.

7.3 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. The sample of these records reviewed was found to have been fully and accurately 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 was recorded in controlled drug record books.

Daily stock counts were maintained for all medicines. In addition, a range of audits were carried out by the manager. The date of opening was recorded on the majority of medicines so that they could be easily audited. This is good practice.

7.4 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 one resident who had a recent hospital stay. A hospital discharge letter had been received and a copy had been forwarded to the resident's GP. The resident's personal medication record had been updated to reflect the 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.

7.5 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.

7.6 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. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

8.0 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 with respect to the management of medicines.

The outcome of this inspection concluded that the area for improvement identified at the last medicines management inspection had been addressed. One new area for improvement in relation to the timely disposal of discontinued medicines was identified.

We can conclude that the residents were administered their medicines as prescribed by their GP.

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

9.0 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 Annette Martin, Manager, 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.

9.1 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).

9.2 Actions to be taken by the home

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 the Web Portal for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection onwards	The registered person shall ensure that discontinued medicines are removed from the medicines trolley and medicines cupboards without delay to ensure that discontinued medicines are not administered in error. Ref: 7.2
	Response by registered person detailing the actions taken: A meeting was held with all senior care staff to discuss importance of removing discontinued medication from the medicine trolley and medication cupboard without delay to ensure that dicontinued medicines are not administered. The manager commenced monitoring check to ensure compliance.

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

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