Inspection Report
2 March 2021

Glenabbey Manor

Type of Home: Residential Care Home
Address: 93 - 97 Church Road, Glengormley, Newtownabbey, BT36 6HG
Tel No: 028 9084 3601
Inspector: Rachel Lloyd

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 76 residents.

2.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Mr Gavin O'Hare-Connolly	**Registered Manager and date registered:** Mrs Liza Lorimer (registration pending)
Person in charge at the time of inspection: Mrs Liza Lorimer	**Number of registered places:** 76 A maximum of 48 residents in category RC-I; 19 accommodated on the ground Floor and 29 accommodated on the second Floor. A maximum of 28 residents in category RC-DE accommodated on the first Floor.
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:** 49

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 2 March 2021 from 10.00 to 14.00. A sample of medicines and records on two of the three floors/treatment rooms was examined.

Short notice of the inspection was provided to the manager the afternoon before the inspection in order to ensure that arrangements could be made to safely facilitate the inspection in the home.

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
- medicine receipt and disposal
- controlled drugs
- care plans related to medicines management
- governance and audit
- staff training and competency
- medicine storage temperatures
- management of medication incidents

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	2*	3*

The total number of areas for improvement includes five that have been carried forward for review at a future care inspection. This inspection resulted in no new areas for improvement being identified.

Findings of the inspection were discussed with Mrs Liza Lorimer, Manager, and the Operations Director, 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 (16 & 18 September 2020) and last medicines management inspection (4 March 2019)?

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

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Residential Care Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 20(1) (a)

Stated: First time</td><td>The registered person shall ensure that at all times suitably qualified, competent and experienced persons are working in the home in such numbers as are appropriate for the health and welfare of residents.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and will be carried forward to the next care inspection.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Regulation 29(4) (b) (c)

Stated: First time</td><td>The registered person shall ensure that the reports of the monthly monitoring visits by the registered provider include the following:

• the specific period reviewed for accidents and incidents
• all actions partially or not fully completed carried forward to the next month</td><td rowspan="2">Carried forward to the next inspection</td></tr>
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Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		Validation of compliance
Area for improvement 1 **Ref**: Standard 17.1 **Stated:** Second time	The registered person shall ensure that all complaints are fully documented in line with the company's policies and procedures and best practice.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and will be carried forward to the next care inspection.	
Area for improvement 2 **Ref**: Standard 13 **Stated:** First time	The registered person shall ensure that effective arrangements are in place to provide consistent, person centred activities to residents.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and will be carried forward to the next care inspection.	
Area for improvement 3 **Ref**: Standard 12.10 **Stated:** First time	The registered person shall ensure the following: • Speech and Language Therapy recommendations are clarified, where necessary • resident's care records contain clear directions for staff at all times in relation to the level of supervision each resident requires with eating and drinking.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and will be carried forward to the next care inspection.	

6.0 What people told us about this home?

Residents were observed to be relaxing in the lounges. A designated area to enable residents to receive visitors was in use throughout the inspection and staff were on hand to facilitate this.

Staff interactions with residents and any visitors were warm and friendly and it was evident that they were familiar with their roles and responsibilities and they knew the residents well.

We met with the three care team leaders, the manager and the operations director. 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 were complimentary about the staff team and communication in the home. They advised that they had the appropriate training to look after residents and meet their needs.

Feedback methods included a staff poster to facilitate feedback 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 responses 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 the GP, the pharmacist or during a hospital admission.

Residents in the home were registered with a local 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. at medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. It was acknowledged by the manager that some of them had been updated just prior to the inspection. 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.

Obsolete personal medication records had been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the resident.

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 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. Records of administration were clearly recorded. The reason for and outcome of administration were recorded in the daily progress notes and on additional "when required" administration recording sheets.

The management of pain was examined. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required. Care plans were in place.

Some residents may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the resident should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the resident. We reviewed the management of thickening agents for two residents. A speech and language assessment report and care plan was in place. Records of prescribing and administration were maintained.

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.

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 medicine refrigerator and controlled drugs cabinet were available for use in each unit.

It was agreed that spacer devices, for use with inhaled medicines, would be stored covered and labelled with the resident's name for infection prevention and control purposes. This was addressed immediately.

We reviewed the disposal arrangements for medicines. Discontinued medicines were returned to the community pharmacy for disposal and records maintained.

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. A sample of these records was reviewed. These records were found to have been fully and accurately completed. Completed records were filed appropriately. In addition, separate administration records for transdermal patches, "when required medicines" and topical medicines were used and these were well maintained.

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 were recorded appropriately in controlled drug record books.

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.

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.

The admission records for two recent admissions were examined. There was evidence that robust procedures were in place to obtain written confirmation of the resident's medicine regime and the accurate completion of the relevant medicine records.

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 usually annually thereafter. A small number of competency assessments were overdue for review; however, this had been identified and was recorded in the action plan for completion by the end of March 2021. 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.

The outcome of this inspection concluded that the residents were being administered their medicines as prescribed. No new areas for improvement were identified.

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

9.0 Quality Improvement Plan

There were no new areas for improvement identified during this inspection. The QIP includes areas for improvement which have been carried forward for review at the next care inspection only.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 20(1) (a) **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that at all times suitably qualified, competent and experienced persons are working in the home in such numbers as are appropriate for the health and welfare of residents. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and will be carried forward to the next care inspection.** Ref: 5.0
Area for improvement 2 **Ref:** Regulation 29(4) (b) (c) **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that the reports of the monthly monitoring visits by the registered provider include the following: • the specific period reviewed for accidents and incidents • all actions partially or not fully completed carried forward to the next month **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and will be carried forward to the next care inspection.** Ref: 5.0
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Area for improvement 2 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 30 October 2020	The registered person shall ensure that effective arrangements are in place to provide consistent, person centred activities to residents. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and will be carried forward to the next care inspection.** Ref: 5.0

Area for improvement 3 **Ref**: Standard 12.10 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure the following: • Speech and Language Therapy recommendations are clarified, where necessary • resident's care records contain clear directions for staff at all times in relation to the level of supervision each resident requires with eating and drinking.
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