The Regulation and Quality Improvement Authority

Inspection Report

8 June 2021

Trinity House

Type of Service: Residential Care Home
Address: 15 Kilrea Road, Coleraine, BT51 5LP
Tel No: 028 2954 8128

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Presbyterian Council of Social Witness **Responsible Individual:** Mr Lindsay Conway	**Registered Manager:** Mrs Jayne Bellingham **Date registered:** 10 April 2018
Person in charge at the time of inspection: Ms Claire Duffin, Deputy Manager	**Number of registered places:** 50 This number includes: a maximum of 34 residents in category RC-I (old age not falling within any other category), and a maximum of 16 residents in category RC-DE (dementia).
Categories of care: Residential Care (RC) I – old age not falling within any other category. DE – dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 48
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 50 residents.	

2.0 Inspection summary

An unannounced inspection took place on 8 June 2021 from 10.15am to 2:00pm. The inspection was carried out by a pharmacist inspector.

This inspection focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified since the last medicines management inspection.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure

compliance with legislation, standards and best practice, and to address any deficits identified during our 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 residents
- 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
- medicine storage temperatures
- RQIA registration certificate

4.0 What people told us about the service

The inspector met with the home administrator, a senior care assistant and the deputy manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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

In order to reduce footfall throughout the home, the inspector met with a small number of residents briefly. The residents did not raise any concerns regarding the care provided and stated they enjoyed living in the home.

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 home 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.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

The last inspection to this residential care home was a care inspection undertaken on 26 January 2021. No areas for improvement were identified.

Areas for improvement from the last medicines management inspection on 20 November 2018		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 6.2 **Stated:** First time	The registered person shall implement care plans, for those residents whose specific health needs involve the community nursing team, identifying the signs that staff should be aware of which indicate that their health is deteriorating and the subsequent action that should be taken.	**Met**
	Action taken as confirmed during the inspection: Care plans and risk assessments were in place for one resident's health needs which involved community nursing, specifically warfarin. Staff were aware of signs that the resident's health may be deteriorating and knew the subsequent action to take to ensure the resident received the appropriate care.	

5.2 Inspection findings

5.2.1 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 the 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 of 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, for example, during medication reviews and at 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. Records of administration were clearly recorded. The reason for and outcome of administration were recorded in supplementary "when required" medication administration records. However, care plans did not record which medicines were prescribed. The deputy manager and senior care assistant agreed to update the care plans immediately following the inspection.

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.

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. Care plans had not been fully updated to reflect the current speech and language therapist (SALT) assessment report or written reflecting the international dysphagia diet standardisation initiative (IDDSI) guidance. Staff were unable to locate the latest SALT assessment report for one resident. We were assured at the time of inspection that the resident was receiving the correct diet and further assurances were sought post inspection to ensure this was correct.

Records of prescribing included the thickening agent prescribed but did not detail the recommended consistency of fluids to be administered. Administration of thickening agents had not been recorded. An area for improvement was identified.

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

Medicine 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 as needed.

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

5.2.3 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. The records were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for audit/review.

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 in a controlled drug record book.

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 medicine cups used to administer medicines to residents were labelled as single use. Therefore, they should be discarded after each use. Staff advised that the cups are sterilised after use and reused. This matter was discussed with the manager following the inspection who gave an assurance that the necessary arrangements would be made to ensure this practice is stopped.

5.2.4 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 was recently admitted from home. Satisfactory systems were in place to ensure medicines had been accurately received into the home and administered in accordance with the most recent directions.

5.2.5 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.

Audits completed by the inspector indicated that residents were being administered their medicines as prescribed

5.2.6 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. Policies and procedures should be up to date and readily available for staff use.

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.

Records of staff training in relation to medicines management were available for inspection.

6.0 Conclusion

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 area for improvement identified at the last medicines management inspection had been addressed. One new area for improvement in relation to nutritional care plans and the management of thickening agents was identified. Details of this are included in the Quality Improvement Plan.

Whilst we identified an area for improvement, we can conclude that overall, the residents were being administered their medicines as prescribed.

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

7.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with the Residential Care Home Regulations (Northern Ireland) 2005 and the Residential Care Homes Minimum Standards (2011).

	Regulations	Standards
Total number of Areas for Improvement	1	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Claire Duffin, Deputy Manager, and Natasha Elder, Senior Care Assistant as part of the inspection process. A follow up telephone call was also made to Jayne Bellingham, Registered Manager, to communicate the findings of the inspection. The timescales for completion commence from the date of inspection.

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	The registered person shall ensure that nutritional care plans for residents prescribed a modified diet are reflective of the current SALT and IDDSI guidance. Records of prescribing and administration of thickening agents including the recommended consistency of fluids should be maintained Ref: 5.2.1
	Response by registered person detailing the actions taken: New files have been opened for the residents assessed by SALT. Each one has their own file with their most recent SALT plan at the front, it also includes a daily recording sheet for all times thickener is used for each indiviual, recording the amount fo liquid and the scoops used. The files also contain a pictorial guide for all staff to ensure consistency is maintained.

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

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