The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Trinity House

Provider: Presbyterian Council of Social Witness

Date of Inspection: 22, 23 and 28 January 2025

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 Dermot Parsons
Registered Manager:	Mr Andrew Harbottle, not registered
Service Profile: Trinity House is a residential care home registered to provide health and social care for up to 50 residents. The home is located on one level and is registered to provide both general residential care and care for residents living with dementia.	

2.0 Inspection summary

An unannounced inspection took place on 22 January 2025 between 10.15 am and 4.50 pm and on 23 January 2025 between 9.50 am and 1.50 pm, by a care inspector; and on 28 January 2025 from 10.30am to 3.05pm, by a pharmacist inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified by RQIA, during the last care inspection on 30 April 2024 and the last medicines management inspection on 8 June 2021; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to residents and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

While care was found to be delivered in a safe and compassionate manner, improvements were required to ensure the effectiveness and oversight of the care delivery.

Mostly satisfactory arrangements were in place for the safe management of medicines. However, whilst areas for improvement were identified, there was evidence that residents were being administered their medicines as prescribed.

Residents were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the residents well.

Residents generally provided positive feedback about their experiences living in the home. Details can be found in Section 3.2.

As a result of this inspection six areas for improvement were assessed as having been addressed by the provider. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the 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 areas for improvement issued, registration information, and any other written or verbal information received from resident's, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Residents provided generally positive but mixed feedback about their experiences residing in the home. For example, some residents provided positive feedback about the support provided by staff and said that the staff offered choices to them throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Comments made by residents that were less complimentary relating to the use of agency staff in the home and the provision of activities; were shared with the management team for review and action as appropriate.

One visitor spoken with provided positive feedback about the home, they said "my friend always seems very content" and "I leave happy because I know that my friend is happy."

A healthcare professional who was visiting the home said that they regularly visited the home and felt that communication was good and staff knew the residents well.

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. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each resident liked to take their medicines and medicines were administered in accordance with individual resident preference. Staff also said that they prioritised residents who required pain relief and time-critical medicines during each medicine round.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of residents. There was evidence of robust systems in place to manage staffing. A discussion took place with the management team to ensure the duty rota clearly reflected the current management arrangements. Assurances were provided by the management team this would be addressed.

Residents said that there was enough staff on duty to help them. Comments regarding the use of agency staff were shared with the management team. There was evidence of systems in place to promote continuity of care when agency staff are required and the management team confirmed that staffing and the use of agency staff was kept under regular review.

Staff said there was good team work, that they felt well supported in their role and that they were satisfied with the staffing levels. A discussion took place with the management team regarding staffing levels for housekeeping staff in the home. Assurances were provided that this was under review and action would be taken to ensure there was adequate cleaning staff on duty.

3.3.2 Quality of Life and Care Delivery

Staff were knowledgeable of individual residents' needs, their daily routine wishes and preferences. Throughout the day observation confirmed that staff attended safety briefings/ 'safety pauses' prior to mealtimes to ensure good communication across the team about changes in residents' needs.

Staff were observed to be prompt in recognising residents' needs and any early signs of distress or illness, including those residents who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs.

It was observed that staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly. Staff were also observed offering residents choice in how and where they spent their day or how they wanted to engage socially with others.

At times some residents may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard residents and to manage this aspect of care.

Examination of care records and discussion with staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. For example, residents were referred to their GP or for physiotherapy.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified.

The dining experience was an opportunity for residents to socialise, music was playing, and the atmosphere was calm, relaxed and unhurried. It was observed that residents were enjoying their meal and their dining experience. Prior to the mealtime staff held a safety pause to consider those residents who required a modified diet. It was observed that staff had made an effort to ensure residents were comfortable, had a pleasant experience and had a meal that they enjoyed.

The weekly programme of social events was displayed on the noticeboard advising of future events. Residents provided mixed feedback about their experience of activities in the home. Whilst there was evidence of planned events, residents' involvement with these was not always evident as records were not maintained to evidence the delivery or outcome of activities in the home. An area for improvement was identified.

3.3.3 Management of Care Records

Residents' needs were assessed by a suitably qualified member of staff at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents' needs and included any advice or recommendations made by other healthcare professionals.

Residents care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the residents' needs. Care staff recorded regular evaluations about the delivery of care. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate.

Supplementary documentation regarding the recording of residents' food and fluid intakes for those who had these in place did not always accurately record fluid targets and fluid totals. A discussion took place with the management team and assurances were provided this would be addressed.

3.3.4 Quality and Management of Residents' Environment

The home was clean, tidy and well maintained. For example, residents' bedrooms were personalised with items important to the resident. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable, for example; 'homely' touches such as flowers, newspapers, magazines and snacks and drinks were available.

There was evidence of some environmental deficits which had not be identified in environmental checks/audits, for example; damage to a fire door. Assurances were provided by the manager that these deficits had been addressed before the conclusion of the inspection.

There was a malodour detectable in one named bedroom; the manager provided written assurances following the inspection that this had been addressed.

A discussion took place with the management team regarding the need for environmental and Infection Prevention Control (IPC) audits to be reviewed to ensure they were robust given the inspection findings; and that time bound action plans were drawn up and signed off when completed. An area for improvement was identified.

3.3.5 Quality of Management Systems

Mr Andrew Harbottle has been the Manager in this home since 19 September 2024 and is currently acting as the registered manager.

Staff commented positively about the senior staff and management team and described them as supportive and approachable.

The manager is currently undertaking the 'My Home Life' course run by the University of Ulster to enhance their managerial and leadership role and to share learning with the staff team.

Review of a sample of records evidenced that a system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

The home was visited each month by a representative of the registered provider to consult with residents, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail. Action plans developed as a result of these visits were not always completed within timeframes. An area for improvement was identified.

3.3.6 The Management of Medicines

Monitoring and review of medicines management

Residents in residential 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 may 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 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, at medication reviews or hospital appointments.

The personal medication records reviewed 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 confirm that they were accurate.

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

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 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.

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Directions for use were clearly recorded on the personal medication record. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain and other factors. However, resident-centred care plans, with sufficient detail to direct care, were not in place for all residents prescribed these medicines. The reason for and outcome of each administration was not consistently recorded. Staff were also reminded that the prescriber should be made aware if these medicines are administered on a regular basis. An area for improvement was identified.

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. Care plans were in place and reviewed regularly for many residents, however for others, resident-centred care plans with sufficient detail to direct care, were not in place or were not up to date. An area for improvement was identified.

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.

The management of thickening agents and nutritional supplements was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained. Staff agreed to update one care plan with a recently prescribed change. The resident was receiving the correct consistency.

Supply, storage and disposal of medicines

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.

Records reviewed 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 medicine 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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately.

Medicines which were self-administered, including external preparations were stored securely residents' bedrooms.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. Staff were reminded that the medicines refrigerator thermometer should be reset each day after recording temperatures, to ensure that temperatures remain within the necessary range.

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 should be recorded in the controlled drug record book.

Two controlled drugs which require safe storage in the controlled drugs cupboard were stored on medicine trolleys. For one of these, the required records were not in place in the controlled drug record book. An area for improvement was identified.

Satisfactory arrangements were in place for the safe disposal of medicines.

Medicines administration

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

Accurate records of medicines received must be maintained to facilitate a clear audit trail. Some incoming medicines had not been recorded, particularly acute medicines received outside of the monthly order, for example, antibiotics. This was discussed and it was agreed that a consistent record of medicines ordered and received would be used. An area for improvement was identified.

A sample of the medicines administration records was reviewed. Records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Residents may be prescribed injections which are administered by community nurses who maintain their own record of administration. This had changed recently from a paper to an electronic record, to which staff in the home have no access. Staff were reminded that they should maintain a record of the date last administered and the date the next dose is due in resident records.

Occasionally, residents may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the resident's care plan. Written consent and care plans were in place when this practice occurred.

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 the majority of medicines so that they could be easily audited. Running stock balances were in place for medicines not supplied in the monitored dosage system, this is good practice. However, two formats of the recording sheet were in use and one did not include the date of administration. It was agreed that this would be addressed following the inspection.

It was agreed that the findings of this inspection would be included within the monthly audit for ongoing monitoring.

Transfer of medicines

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines at the time of admission or for residents returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

Management of medicines 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. A robust audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

Medicines management training

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 they staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Medicines management policies and procedures were in place.

It was agreed that the findings of this inspection would be discussed with staff and any necessary training provided to facilitate ongoing improvement.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	1	6

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Andrew Harbottle, Manager, and the regional manager as part of the inspection process. 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:** 28 January 2025	The registered person shall ensure that suitable arrangements are in place for the management and storage of controlled drugs. Ref: 3.3.6
	Response by registered person detailing the actions taken: The registered Manager has liaised with the aligned pharmacy to ensure that all controlled drugs are supplied separately, to facilitate separate storage within the controlled drug cupboard. The registered Manager has communicated with the senior staff in the home, so if they are unsure of the classifications of controlled drugs they will liaise with the pharmacy or GP to ensure that all controlled drugs are identified and stored appropriately. Controlled drug records will also be reviewed during the monthly monitoring visits.
Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022	
Area for improvement 1 **Ref:** Standard 13 **Stated:** First time **To be completed by:** 23 January 2025	The registered person shall ensure a meaningful record is kept of activities that take place in the home, for example, the name of the person leading the activity, the names of the residents who participate and if residents enjoyed or benefitted from the planned activity. Ref: 3.3.2
	Response by registered person detailing the actions taken: The registered manager has produced a daily activity record document for each individual resident. All staff will record all group activity participants and the outcome for all who participate. All staff will also record within this record all residents who are offered to participate but decline. Individual residents' activity choices are also identified and documented. This will be signed by the individual staff member. During the Monthly Monitoring Visits (MMVs), the Regional Manager will check the activity records for evidence of completion.

Area for improvement 2 **Ref:** Standard 20.10 **Stated:** First time **To be completed by:** 20 February 2025	The registered person shall ensure audits are robust by including a time bound action plan and sign off the actions to evidence when these are completed. This is with specific reference to environmental and IPC audits. Ref: 3.3.4
	Response by registered person detailing the actions taken: The registered manager, has been completing, and will continue to complete, a monthly audit analysis which is inclusive of all identified actions within the audit process, outstanding actions, and what has been completed and what measures are in place to ensure all actions are completed in a timely manner. The Regional Manager will complete a review of all actions identified throughout the audit process, during the monthly monitoring visits.
Area for improvement 3 **Ref:** Standard 20.11 **Stated:** First time **To be completed by:** 23 January 2025	The registered person shall ensure the actions identified as part of the monthly monitoring visits are addressed within the agreed timeframes. Ref: 3.3.5
	Response by registered person detailing the actions taken: On completion of the monthly monitoring visit, the registered Manager will have an agreed action plan from the findings of the visit. This will be reviewed by the Regional Manager within the next month's MMV visit. This will also be a focus area within the one-to-one monthly supervision with the service Manager and aligned Regional Manager, to ensure that any agreed actions are completed in a timely manner. With regards to the identified outstanding actions within the monthly monitoring visits identified during the inspection, the registered Manager has investigated and made a report to the relevant external bodies.
Area for improvement 4 **Ref:** Standard 31 **Stated:** First time **To be completed by:** With immediate effect (28 January 2025)	The registered person shall ensure that records of medicines received are accurately maintained. Ref: 3.3.6
	Response by registered person detailing the actions taken: The registered Manager has developed and implemented a medication recording book, which focuses on ensuring that there is a clear record of all medications received into the home, as well as creating a clear record of medications that are required to be returned to the pharmacy. A review of medication records will be completed by the Regional Manager during the monthly monitoring visits.

Area for improvement 5 **Ref:** Standard 10 **Stated:** First time **To be completed by:** 4 February 2025	The registered person shall ensure that the management of distressed reactions is reviewed to include a care plan, record the reason for and outcome of the administration of medicines prescribed for use on a 'when required' basis and to inform the prescriber if these medicines are used on a regular basis. Ref: 3.3.6
	Response by registered person detailing the actions taken: The registered Manager and the senior team within Trinity House, have developed care plans for all residents who are prescribed PRN medications for distressed reaction. Alongside this the management team have put into place the PRN protocol to ensure that staff are monitoring the reason and the effectiveness of prescribed PRN medications. This will be reviewed monthly and communicated with the GP or Community Mental Health team for a review. The Regional Manager, on completion of the monthly drug audit trails within the monitoring visit, will observe the use of the PRN protocols, whilst cross referencing the PRN protocol to the care plan.
Area for improvement 6 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 4 February 2025	The registered person shall ensure that resident specific care plans for the management of pain are in place that include details of prescribed medicines where relevant. Ref: 3.3.5
	Response by registered person detailing the actions taken: The registered Manager and the senior team within Trinity House have developed detailed care plans for all residents who are prescribed PRN pain relief. Alongside this, the PRN protocol is in place to enable staff to staff to monitor the reason for dispensing as well as the effectiveness of the prescribed PRN pain relief. This will be reviewed monthly and communicated with the GP for a medication review, if required. The Regional Manager, on completion of the monthly drug audit trails within the Monitoring Visit, will monitor the use of the PRN protocols.

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