The Regulation and Quality Improvement Authority

# Inspection Report

## 20 May 2021

# Three Rivers Residential Care Home

Type of service: Residential Care Home
Address: 11 Millbank Lane, Lisnamallard, Omagh, BT79 7YD
Telephone number: 028 8225 8227

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

## 1.0 Service information

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| **Organisation/Registered Provider:**<br>Zest Investment (Omagh) Ltd<br><br>**Responsible Individual:**<br>Mr Philip Scott | **Registered Manager:**<br>Ms Jillian (Claire) McKenna, Acting Manager |
| **Person in charge at the time of inspection:**<br>Ms Claire McKenna | **Number of registered places:**<br>25 |
| **Categories of care:**<br>Residential Care (RC):<br>DE – dementia | **Number of residents accommodated in the residential care home on the day of this inspection:**<br>10 |
| **Brief description of the accommodation/how the service operates:**<br>Three Rivers Residential Care Home is a residential care home with 25 beds that provides care for residents who are living with dementia. The home is situated on the same site as Three Rivers Care Centre (nursing home). | |

## 2.0 Inspection summary

An unannounced inspection took place on 20 May 2021 between 10.30 am and 2.10 pm. The inspection was completed by a pharmacist inspector.

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.

## 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 information held by RQIA about this home was reviewed. This included previous inspection findings, incidents and correspondence.

To complete the inspection: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines were reviewed.

During the inspection the inspector:

- 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

## 4.0 What people told us about the service

The inspector met with the manager, two nurses and a senior care assistant. 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 the 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.

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 returned.

## 5.0 The inspection

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

| Areas for improvement from the last inspection on 18 and 23 June 2020 | | |
|---|---|---|
| **Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005** | | **Validation of compliance summary** |
| **Area for improvement 1**<br><br>**Ref**: Regulation 29 (3) and (4)<br><br>**Stated:** First time | The registered person shall ensure that the visits by the registered provider's representative are completed on a monthly basis and a written report made available in relation to this visit. | **Carried forward to the next inspection** |
| | **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** | |
| **Area for improvement 2**<br><br>**Ref**: Regulation 30 (1) (d)<br><br>**Stated:** Second time | The registered person shall ensure that RQIA are informed of any incidents where medical advice or attention is sought. | **Carried forward to the next inspection** |
| | **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** | |
| **Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)** | | **Validation of compliance summary** |
| **Area for improvement 1**<br><br>**Ref**: Standard 31<br><br>**Stated:** First time | The registered person shall ensure that hand-written entries on the medication administration records are verified and signed by two members of staff. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Hand-written entries on the medication administration records were verified and signed by two members of staff. | |

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|---|---|---|
| **Area for improvement 2**<br><br>**Ref**: Standard 19.3<br><br>**Stated:** First time | The registered person shall ensure that the AccessNI certificate is retained in accordance with the AccessNI code of practice. | **Carried forward to the next inspection** |
| | **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.** | |

## 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 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 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 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 were 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 records of administration were accurately maintained. The reason for and outcome of administration were recorded. However, care plans did not record which medicines were prescribed. The manager and senior carer agreed to update the care plans immediately following the inspection.

The management of pain was reviewed. Care plans were in place and pain assessment tools were used. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required. The reason for and outcome of each administration was recorded.

### 5.2.2 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 residents' 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.

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. 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 were accurately 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 washed after use and then reused. This matter was discussed with the manager who gave an assurance that the necessary arrangements would be made to ensure that 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.

The management of medicines for one recent admission was reviewed. Satisfactory systems were in place. A list of their prescribed medicines had been provided by family and this was verified in writing by the GP. The medicines had been accurately received in the home and were administered as prescribed.

### 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.

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.

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.

### 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.

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.

## 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 in relation to medicines management had been addressed. No new areas for improvement were identified. We can conclude that overall the residents were being administered their medicines as prescribed by their GP.

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

## 7.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no new areas for improvement being identified.

Areas for improvement were carried forward 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** | 2* | 1* |

* The total number of areas for improvement includes two under the regulations and one under the standards which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Claire McKenna, Manager, as part of the inspection process.

| Quality Improvement Plan | |
|---|---|
| **Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005** | |
| **Area for improvement 1**<br><br>**Ref**: Regulation 29 (3) and (4)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>1 August 2019 | The registered person shall ensure that the visits by the registered provider's representative are completed on a monthly basis and a written report made available in relation to this visit. |
| | **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 5.1 |
| **Area for improvement 2**<br><br>**Ref**: Regulation 30 (1) (d)<br><br>**Stated:** Second time<br><br>**To be completed by:**<br>19 June 2020 | The registered person shall ensure that RQIA are informed of any incidents where medical advice or attention is sought. |
| | **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 5.1 |
| **Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)** | |
| **Area for improvement 1**<br><br>**Ref**: Standard 19.3<br><br>**Stated:** First time<br><br>**To be completed by:**<br>19 June 2020 | The registered person shall ensure that the AccessNI certificate is retained in accordance with the AccessNI code of practice. |
| | **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**<br><br>Ref: 5.1 |

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