Inspection Report
13 October 2020

Weavers House Residential Care Home

Type of Service: Residential Care Home
Address: 40 Moneymore Road, Cookstown, Tyrone BT80 8EH
Tel No: 028 8676 7684
Inspector: Paul Nixon

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 registered residential care home which provides care for up to 47 residents.

2.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Mr Gavin O'Hare-Connolly	**Registered Manager and date registered:** Miss Andrea Harkness 12 June 2020
Person in charge at the time of inspection: Miss Andrea Harkness	**Number of registered places:** 47
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE – Dementia	**Number of residents accommodated in the residential home on the day of this inspection:** 43

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 13 October 2020 from 09.40 to 12.40. Short notice of the inspection was provided of 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. The inspection also assessed progress with any areas for improvement identified at or since the last medicines management inspection and one area for improvement identified at the last 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 were 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 medicines management training and competency records
- medicine storage temperatures
- RQIA registration certificate

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Miss Andrea Harkness, Registered Manager, as part of the inspection process and can be found in the main body of the report.

One area for improvement identified at the last care inspection was not reviewed and is carried forward to the next care inspection.

Enforcement action did not result from the findings of this inspection.

5.0 What has this service done to meet any areas for improvement identified at or since the last care inspection on 18 August 2020 and last medicines management inspection on 26 July 2018?

Areas for improvement from the last medicines management inspection		
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 32 **Stated:** First time	The registered person shall review the storage of medicines as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: All medicines were stored securely and in accordance with the manufacturer's instructions.	
Area for improvement 2 **Ref**: Standard 33 **Stated:** First time	The registered person shall review the administration of inhaled medicines to ensure that these are administered as prescribed.	**Met**
	Action taken as confirmed during the inspection: The administration of inhaled medicines had been reviewed to ensure that these were administered as prescribed. Running stock balances were maintained. The audits performed on inhaled medicines produced satisfactory outcomes.	

Areas for improvement from the last care inspection		
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 6.2 **Stated:** First time	The registered person shall ensure that care plans are reflective of the needs of the residents, including any recommendations from other professionals.	**Met**
	Action taken as confirmed during the inspection: A selection of medicines related care plans was reviewed in relation to the use of thickeners, pain management and the use of medicines prescribed for administration on a "when necessary" basis for the management of distressed reactions. These were reflective of the needs of the residents and, where relevant, included any recommendations from other professionals.	
Area for improvement 2 **Ref**: Standard 8.2 **Stated:** First time	The registered person shall ensure that the daily evaluations of care are meaningful and reflective of the current situation of the resident.	**Carried forward to the next care inspection**
	Action taken as confirmed during the inspection: ***Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.***	

6.0 What people told us about this service

Observation of the delivery of care evidenced that staff attended to residents needs in a timely and caring manner. Staff were warm and friendly and obviously knew the residents well. The home was observed to be clean and warm; there were no malodours. Corridors were free from trip hazards.

Staff spoken to expressed satisfaction with how the home was managed and with their training opportunities. They said that management was supportive and responsive to any suggestions or concerns raised.

Feedback methods also included a staff poster and paper questionnaires which were provided to the registered manager for any resident or their family representatives to complete and return using pre-paid, self-addressed envelopes. No questionnaires were completed within the timeframe for inclusion in this report.

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 medical 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 the GP, the 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 contained a list of all 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, transfers to hospital. The records reviewed had been fully and accurately completed. In line with best practice, a second member of staff checked and signed these records when they were updated to provide a double check that they were accurate.

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, antibiotics, warfarin, modified diets, self-administration etc.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Care plans were in place and directions for use were clearly recorded on the personal medication records. These medicines were infrequently used.

Satisfactory systems were in place for the management of pain and thickening agents.

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

Medicines must be available to ensure that they are administered to residents as prescribed and when they require them. It is important that they are stored safely and securely and disposed of promptly so that there is no unauthorised access.

The records inspected showed that medicines were available for administration when residents required them. The registered manager advised that she 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. They were tidy and organised so that medicines belonging to each resident could be easily located. The medicines currently in use were stored within medicine trolleys that were also securely stored so that there could be no unauthorised access. Controlled drugs were stored in controlled drug cabinets.

When medicines needed to be stored at a colder temperature, they were stored within the medicines refrigerators and the temperatures of these refrigerators were monitored.

Medicines disposal was discussed with the registered manager. Medicines were returned to the community pharmacy regularly and were not allowed to accumulate in the home. Disposal of medicine records were examined and had been completed so that all medicines could be accounted for.

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) when medicines are administered to a resident. A sample of these records was reviewed which found that they had been fully and accurately completed. The completed MARs were filed once 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 recorded in controlled drug record books. We found that controlled drugs were safely managed in the home and that records were accurately maintained.

Management audits medicine administration on a weekly basis within the home. The audits showed that medicines had been given as prescribed. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

Audits completed during this inspection also showed that medicines had been given as prescribed.

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 two residents who had recently been admitted to the home. In each instance, the medicines prescribed had been confirmed with the resident's GP. The resident's personal medication record had been accurately written and, in line with best practice, a second member of staff had checked and signed the records to provide a double check that they were accurate.

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 that 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 would help staff to identify medicine related incidents. The registered manager and staff were familiar with the type of incidents that should be reported.

There had been several medication related incidents identified since the last medicines management inspection. There was evidence that the incidents had been investigated and learning had been shared with staff. The incidents had been reported to the prescribers for guidance and to the appropriate authorities including RQIA.

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 that 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

This inspection sought to assess if the home was delivering safe, effective and compassionate care and if the service was well led.

The outcome of this inspection concluded that all areas for improvement identified at the last medicines management inspection had been addressed and no new areas for improvement were identified. The registered provider had taken the appropriate actions to ensure that any previous areas for improvement had been addressed and improvements were sustained. We can conclude that residents and their relatives can be assured that medicines were well managed within the home.

One of the two areas for improvement identified at the last care inspection was not reviewed and is carried forward to the next care inspection, the other had been addressed. The other area for improvement was assessed as met.

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 Miss Andrea Harkness, Registered 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 service

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 Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 8.2 **Stated:** First time **To be completed by:** 19 August 2020	The registered person shall ensure that the daily evaluations of care are meaningful and reflective of the current situation of the resident. Ref: 5.0
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.

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

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