The Regulation and Quality Improvement Authority

Inspection Report

26 May 2021

Oak Tree Manor Residential Home

Type of service: Residential Care Home
Address: 2A Hazel Avenue, Dunmurry, Belfast
Telephone number: 028 9061 0435

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: Kathryn Homes Ltd **Responsible Individual:** Mr Dermot Parsons	**Registered Manager:** Mrs Tracey Anderson **Date registered:** Registration pending
Person in charge at the time of inspection: Ms Candice Boal, Clinical Lead	**Number of registered places:** 51
Categories of care: Residential Care (RC): DE – dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 42
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 51 residents living with dementia. This home is situated on the same site as Oak Tree Manor Nursing Home.	

2.0 Inspection summary

An unannounced medicines management inspection took place on 26 May 2021, from 10.40am to 15.30pm. The inspection was completed by a pharmacist inspector.

This inspection focused on medicines management within the home. The inspection also assessed progress with areas for improvement identified at the last inspection.

Following discussion with the aligned care inspector, it was agreed that two of the areas for improvement identified at the last inspection would be followed up at the next care inspection.

Overall the management of medicines was satisfactory. Staff were appropriately trained, medicines were safely stored and management of controlled drugs was robust. The majority of medicine records had been fully and accurately completed, however improvement was required in the completion of some of the medicine administration records. An area for improvement was stated for the second time.

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 three care team leaders on duty, the well-being therapist and the clinical lead. 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.

Staff mostly 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 spoke highly of the support given by management and the communication within the home. Some commented that the support of a further care assistant in the mornings would be welcomed.

Feedback methods included a staff poster to facilitate online feedback and paper questionnaires which were provided 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 resident/representative questionnaires had been returned. Three staff responses were received. Of the comments provided, staff reported various levels of satisfaction across the four domains; safe, effective, compassionate and well-led care. Dissatisfaction was reported regarding the management of safety and staffing levels in the home at provider level. However, comments were complimentary regarding the management within the home. The responses were discussed with the manager of the home by telephone for their attention.

5.0 The inspection

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

Areas for improvement from the last inspection on 25 February 2021		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 13 **Stated:** First time	The registered person shall ensure that effective arrangements are in place to ensure that person centred activities are provided to residents in a consistent manner. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next care inspection.**	**Carried forward to the next care inspection**
Area for improvement 2 **Ref:** Standard 6 **Stated:** First time	The registered person shall ensure that care plans for specific medicines administered or provided by staff not employed by the home are in place and detail when these medicines were first administered, next due for administration and if necessary, how and where from they are obtained. **Action taken as confirmed during the inspection**: Care plans were in place for the sample of medicines examined. The relevant information was recorded and available for reference.	**Met**
Area for improvement 3 **Ref:** Standard 32 **Stated:** First time	The registered person shall ensure that medicines with a limited shelf life after opening are used in accordance with the manufacturer's instructions. **Action taken as confirmed during the inspection**: Medicines examined with a limited shelf life after opening were marked with the date of opening and being used in accordance with the manufacturer's instructions.	**Met**

Area for improvement 4 **Ref:** Standard 31 **Stated:** First time	The registered person shall ensure that medication administration records are fully and accurately maintained. Specifically: • Handwritten additions are verified by two members of staff • Entries match personal medication records and reflect the prescriber's most recent instructions.	**Partially met**
	Action taken as confirmed during the inspection: Most handwritten additions had been verified by two members of staff; however several examples were noted where no verification was recorded. The majority of entries on medication administration records examined matched personal medication records and reflected the prescriber's most recent instructions. It was agreed that one highlighted discrepancy would be addressed immediately. However, the separately maintained records of prescribing and administration for topical medication were not always fully and accurately maintained and should be reviewed to ensure they reflect the prescriber's most recent instructions. **This area for improvement was stated for a second time.**	
Area for improvement 5 **Ref:** Standard 30 **Stated:** First time	The registered person shall ensure that the governance of medicine incidents and audits is managed to enable the identification of trends and to drive and sustain improvement. Action plans should be produced and/or followed up to promote reflection and learning.	**Met**
	Action taken as confirmed during the inspection: There was evidence that a programme of medicine audits is completed and medicine incidents are reported to RQIA. Audit outcomes are escalated to management, action plans were in place and the clinical lead confirmed that incidents are shared with staff.	

Area for improvement 6 **Ref:** Standard 12.4 **Stated:** First time	The registered person shall ensure that the daily menu is displayed in a suitable format and in an appropriate location so that residents and their representatives know what is available at each mealtime.	**Carried forward to the next care inspection**
	The clinical lead shared new menus that had been produced in pictorial format, these were planned to be on display in units by as soon as they were ready for display. **Action required to ensure compliance with this standard was not fully reviewed as part of this inspection and this is carried forward to the next care inspection.**	
Area for improvement 7 **Ref:** Standard 20.10 **Stated:** First time	The registered person shall ensure that hand hygiene audit notes the following: • the date of the audit • the name of the assessor • the location within the home where the audit is carried out.	**Met**
	Action taken as confirmed during the inspection: The sample of hand hygiene audits examined included these details and these were available for 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 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 e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were mostly accurate and up to date. It was agreed that one highlighted discrepancy would be addressed immediately. It was also agreed that where medicines are prescribed on a weekly basis, the day of administration would be recorded. 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.

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.

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.

The management of medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed. 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.

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.

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.

We reviewed the management of thickening agents and nutritional supplements. A speech and language assessment report and care plan was in place. It was agreed that the recommended consistency level would added to records of prescribing and administration.

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 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 as needed. It was agreed that inhaler spacer devices would be covered for storage on trolleys for infection prevention and control purposes.

The disposal arrangements for medicines were reviewed. 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. These records were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for review/audit. Records of prescribing and administration for topical medication were separately maintained and were not always fully and accurately maintained. These should be reviewed to ensure that administration reflects the prescriber's most recent instructions. An area for improvement was stated for the second time (see Section 5.1).

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.

Residents, on occasion, may have their medicines administered covertly or in food/drinks to assist administration. Care plans detailing how the residents take their medicines were in place and prescribers had provided written authorisation for each resident.

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.

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.

There had been no recent admissions to the home. However, the admission process for residents new to the home or returning to the home after receiving hospital care were discussed. Records for a recent return to the home were reviewed. Personal medication records had been updated to reflect medication changes which had been initiated during the hospital stay. Arrangements were in place to ensure that staff were provided with a list of prescribed medicines and this was shared with the community pharmacist. Medicines had been accurately received into the home and administered in accordance with the most recent directions. There was evidence that staff had followed up any discrepancies in a timely manner.

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.

A number of 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 learning shared with staff in order to prevent a recurrence. The clinical lead advised that this work to sustain improvement was ongoing and regularly reviewed.

The audits completed during this inspection showed that residents had been given 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. Policies and procedures had been recently reviewed and were readily available for staff use.

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 regarding the management of medicines.

The outcome of this inspection concluded that four areas for improvement identified at the last inspection had been addressed. One area for improvement was stated for a second time as detailed in the report and QIP. Two areas for improvement were carried forward for review at the next inspection.

Whilst we stated one area for improvement for a second time, we can conclude that overall, the residents were being administered their medicines as prescribed. Based on the inspection findings and discussions held, we are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the manager/management team regarding the management of medicines.

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

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have 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	0	3*

* the total number of areas for improvement includes one that has been stated for a second time and two which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Candice Boal, Clinical Lead, 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 Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 13 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that effective arrangements are in place to ensure that person centred activities are provided to residents in a consistent manner.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next care inspection. Ref: 5.1

Area for improvement 2 **Ref:** Standard 31 **Stated:** Second time **To be completed by:** Immediate and ongoing	The registered person shall ensure that medication administration records are fully and accurately maintained. Specifically: • Handwritten additions are verified by two members of staff • Entries match personal medication records and reflect the prescriber's most recent instructions. Ref: 5.1
	Response by registered person detailing the actions taken: This has now been included in a daily monitoring system in place for the CTL in Charge of each shift. This is then reviewed by the Home Manager on a daily basis to ensure this area for improvement is embedded into practice
Area for improvement 3 **Ref:** Standard 12.4 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that the daily menu is displayed in a suitable format and in an appropriate location so that residents and their representatives know what is available at each mealtime.
	Action required to ensure compliance with this standard was not fully reviewed as part of this inspection and this is carried forward to the next care inspection. Ref: 5.1

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The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews