Inspection Report
13 October 2020

Rose Court Residential Home

Type of Service: Residential Care Home
Address: 30 Westbourne Avenue, Ballymena BT43 5LW
Tel No: 028 2564 8165
Inspector: Judith Taylor

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 residential care home which is registered to provide care for up to 82 residents. It is situated in the same building as Rose Court Nursing Home.

2.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Gavin O'Hare-Connolly	**Registered Manager and date registered:** Ashley Currie 20 August 2019
Person in charge at the time of inspection: Ashley Currie	**Number of registered places:** 82 RC-DE – maximum of 29 residents in Maine Suite RC-I - a maximum of 53 residents in the Slemish and Galgorm Suites.
Categories of care: Residential Care (RC): DE – dementia I – old age not falling within any other category	**Total number of residents in the residential care home on the day of this inspection:** 48

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 13 October 2020 from 10.45 to 17.00. Short notice of the inspection was provided to the manager on the morning 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; and also assessed progress with any areas for improvement identified since the last medicines management inspection. Following discussion with the aligned care inspector, it was agreed that two areas for improvement identified at the last care inspection would be followed up at the next 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 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 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 records for medicines management
- staff training and competency records
- medicine storage temperatures
- medicine related incidents

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	2*	1

*The total number of areas for improvement includes two areas for improvement which will be reviewed at a future inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ashley Currie, Registered Manager and one other senior member of staff, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

5.0 What has this home done to meet any areas for improvement identified at the last medicines management inspection (3 September 2019) and last care inspection (11 August 2020)?

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 31 **Stated:** First time	The registered person shall ensure that a record of all incoming medicines is maintained.	**Met**
	Action taken as confirmed during the inspection: Following review of the receipt of medicines records, including recently prescribed medicines, it was evident that records of incoming medicines were maintained.	
Area for improvement 2 **Ref:** Standard 31 **Stated:** First time	The registered person shall ensure that two staff are involved in the transcribing of handwritten entries on medication administration records.	**No longer applicable**
	Action taken as confirmed during the inspection: Since the last medicines management inspection, a new system to record the administration of medicines was implemented; this system does not require the transcribing of any medicine information.	
Area for improvement 3 **Ref**: Standard 30 **Stated:** First time	The registered person should review the arrangements for the disposal of medicines in residential care homes and as per their policy and procedures.	**Met**
	Action taken as confirmed during the inspection: The disposal of medicines processes had been updated and are now managed as per residential care home guidance.	

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Residential Care Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 27(4)(b)

Stated: Second time</td><td>The registered person shall ensure there is no inappropriate storage in an electrical store room at all times.</td><td rowspan="2">Carried forward to the next care inspection</td></tr>
<tr><td>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next inspection.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Regulation 13 (7)

Stated: First time</td><td>The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk and spread of infection.

With specific reference to:
• cleansing wipes and toilet rolls are not stored on toilet cisterns
• pull cords in communal bathrooms and residents bathrooms should be wipe able or have a plastic covering
• staff wearing jewellery.</td><td rowspan="2">Carried forward to the next care inspection</td></tr>
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Ref: Standard 12

Stated: First time</td><td>The registered person shall ensure that:

• the daily menu displayed is reflective of the meal choices available
• food served to residents in their bedrooms should be transported using a tray and with the food covered.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The lunch time meal was served during the time of inspection. The menu was printed and displayed in the dining area reviewed. One menu choice had been revised and was clearly marked. Following discussion with two residents and review of the</td></tr>
</table>

	lunch plate of another resident, the food provided matched the food choices on the menu. We observed one resident's food in their bedroom; there was a tray and food cover for the meal. Staff and management confirmed that these were now in place for all food served in bedrooms.	
Area for improvement 4 **Ref**: Standard 30 **Stated:** First time	The registered person shall ensure that all limited shelf life topical lotions and creams have the date of opening recorded.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this had been addressed with staff and reviewed as part of the audit process.	

6.0 What people told us about this home?

We observed residents relaxing in their bedrooms and lounges. In the afternoon, some were taking part in art activities. We met with four residents. They spoke positively about their care in the home, the food provided and had no concerns regarding their medicines. Comments included:

- "They are so good. Sure you don't have to ask for anything; they know to look at you what you need."
- "Food is good, had a lovely pork chop today."
- "I'm very happy here, this is my home."
- "No complaints at all; they're (staff) great."
- "Am getting on the best."
- "Enjoyed my lunch, the pork chop was really tasty."

Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well and were familiar with their likes and dislikes.

We met with the three senior staff and the registered manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff expressed satisfaction with how the home was managed and advised us they felt supported in their role. They also said that they had the appropriate training to look after residents and meet their needs. It was acknowledged that some staff had worked in the home for several years and were familiar with their roles and responsibilities in the organisation and the home.

Feedback methods included a staff poster and paper questionnaires which were provided to the registered 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 staff questionnaires had been received by RQIA.

Three questionnaires were returned from residents during the inspection. All were marked as very satisfied with their care in the home. Comments included:

- "Very happy."
- "Everything perfect, just like home, food, accommodation."

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 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 the GP, medical consultant or pharmacist.

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 and hospital appointments.

The majority of 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 were written and updated to check that they were accurate. Each medicine entry included the indication for the medicine, for example, 'antihistamine', 'pain relief', 'diuretic' to remind staff what it was prescribed for. A few minor issues were highlighted and addressed during the inspection.

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, diabetes etc. Each of these should include the medicines prescribed. We reviewed a sample of these care plans and found that further detail was required or a care plan needed to be developed. The medicine and dosage was not routinely recorded in pain management care plans and distressed reaction care plans, these should clearly state if a resident can express pain and how this would be expressed. One care plan regarding diabetes needed updated and two care plans regarding distressed reactions needed to be developed.. This was identified as an area for improvement.

7.2 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. A record of all incoming and outgoing medicines must be maintained.

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. Satisfactory arrangements were in place for medicines which required cold storage and access to the controlled drugs cabinets.

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

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. We reviewed a sample of the completed records and evidenced these were accurately maintained; indicating the medicine had been administered as prescribed. We acknowledged the systems in place to alert staff that an antibiotic had been prescribed. The completed records were filed once completed.

In addition to maintaining records of medicine administration, it is necessary to have good governance and auditing systems in place to check if the medicines system is working well or if it requires improvement. Within this home, management, staff and the community pharmacist audit medicine administration on a regular basis and complete a range of audits. To assist with this process, the date of opening was recorded on all medicines containers, daily stock balances were recorded and there was evidence that spot checks were carried out during the medicine cycle. These are areas of good practice.

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 and stock levels were monitored at least twice daily. Each entry in the controlled drug record book should be signed by two staff. We identified that a second signature was missing for a small number of entries; however, acknowledged that they were recorded in the separate daily stock check records. It was agreed that this would be highlighted to staff with immediate effect.

Sometimes residents may need their medicines administered in food/drinks to assist administration or require medicines to be crushed to help them swallow their medicines. There

was evidence that when this was required, this had been discussed in consultation with the resident's GP, who provided a written letter of agreement.

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 systems in place for the management of new residents' medicines and changes to residents' medicines. There were robust systems in place to ensure that written confirmation of their medicine regimes/changes was obtained and details were accurately recorded on the personal medication records. Staff advised that they followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

7.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicine 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.

There had been several medicine related incidents reported since the last medicines management inspection. Whilst it was acknowledged that they had been identified promptly and managed appropriately, these continue to occur. Management advised of the steps being taken to reduce errors within the organisation and the support from the community pharmacist.

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.

There was evidence that staff responsible for medicines management had received induction training and refresher training. A training matrix was maintained. Competency to safely manage medicines had been assessed following induction, annually and also following a medicine related incident.

The manager advised of the procedures in place to ensure that any deficits which were highlighted in staff practice, for example, as a result of audit outcomes, this was addressed through supervision, additional training and review of competency.

8.0 Evaluation of Inspection

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led in relation to medicines management.

We can conclude that the residents were being administered their medicines as prescribed by their GP. There are good systems and processes to monitor medicines management within the home.

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 QIP. Details of the QIP were discussed with Ashley Currie, Registered Manager, and one senior member of staff, 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 home

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 Department of Health, Social Services and Public Safety (DHSSPS) The Residential Care Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref**: Regulation 27(4)(b) **Stated:** Second time **To be completed by:** 4 September 2019	The registered person shall ensure there is no inappropriate storage in an electrical store room at all times. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next inspection.** Ref: 5.0
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the infection prevention and control issues identified during this inspection are managed to minimise the risk and spread of infection. With specific reference to: • cleansing wipes and toilet rolls are not stored on toilet cisterns • pull cords in communal bathrooms and residents bathrooms should be wipe able or have a plastic covering • staff wearing jewellery **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next inspection.** Ref: 5.0

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 6 **Stated:** First time	The registered person shall review the care plans relating to medicines management to ensure they are detailed and include the name of the medicine prescribed. Ref: 7.1
To be completed by: Immediate and ongoing	**Response by registered person detailing the actions taken:** A review of care plans has been undertaken by the registered person; and following a meeting with all care team leaders on 15/10/2020 progress is in place to ensure all residents have care plans relating to medication management which will detail the name of the medicine which is to be prescribed.

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

The Regulation and Quality Improvement Authority

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