The Regulation and Quality Improvement Authority

Inspection Report

1 April 2021

Burleigh Hill Residential Home

Type of service: Residential Care Home
Address: 79 North Road, Carrickfergus, BT38 7QZ
Telephone number: 028 9336 5652

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: M D Healthcare Ltd **Responsible Individual:** Mrs Lesley McGarrity	**Registered Manager:** Mrs Emeliza Insauriga **Date registered:** 23 January 2020
Person in charge at the time of inspection: Mrs Emeliza Insauriga	**Number of registered places:** 21 The total number of registered beds will increase to 23 once an identified nursing patient is no longer accommodated in room 44. Category RC-A for one identified resident only.
Categories of care: Residential Care (RC): A – past or present alcohol dependence I – old age not falling within any other category MP(E) - mental disorder excluding learning disability or dementia – over 65 years PH(E) - physical disability other than sensory impairment – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 20
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 21 residents. This home is situated on the same site as Burleigh Hill House nursing home.	

2.0 Inspection summary

An unannounced inspection took place on 1 April 2021, from 10.40am to 3.00pm by a pharmacist inspector.

This inspection focused on medicines management within the home. It was the first medicines management inspection to the home since registration in 2020. Following discussion with the aligned care inspector, it was agreed that the area for improvement identified at the last care inspection would be followed up at the next care inspection.

There was evidence that robust arrangements were in place for the safe management of medicines and residents were being administered their medicines as prescribed. No new areas for improvement were identified.

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 we reviewed information held by RQIA about this home. This included previous inspection findings, incidents and correspondence. The inspection was completed by reviewing a sample of medicine related records and care plans, medicines storage and the auditing systems used to ensure the safe management of medicines. Staff and residents opinions and views were also obtained.

4.0 What people told us about the service

Residents were relaxed and content in the home. A small number of residents met with the inspector and they spoke positively about their experiences in the home. They were complimentary about the staff, how well they were looked after and said they were happy in the home. No concerns were raised.

Staff interactions with residents were warm, friendly and supportive. It was evident they knew the residents well.

Following discussions with some of the staff on duty, they advised how they enjoyed their job, the teamwork and the support provided. They expressed satisfaction with how the home was managed and advised that they had the necessary training to look after the residents. One issue was raised about staff levels in the afternoon and this was shared with the manager. Details were provided the after inspection of how this was being reviewed.

All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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, two residents and one relative had completed and returned questionnaires to RQIA. All of the responses were positive indicating they were very satisfied with the care provided by the home.

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 23 November 2020		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that RQIA is informed of all notifiable accidents/ incidents appropriately.	**Carried forward to the next inspection**
	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.	

5.2 Inspection outcome

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, for example, at medication reviews or 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 are 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.

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 in the medicines file. Records of administration including the reason for and outcome of administration were maintained.

Pain management was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered as prescribed. Pain assessments were completed at regular intervals and care plans were maintained.

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. Temperatures of medicines storage areas were monitored and recorded every day to ensure that medicines were stored at the correct temperature.

The disposal arrangements for medicines were reviewed. Whilst these were safe and the relevant records were maintained, the processes in use were for the disposal of medicines in nursing homes. This was discussed and addressed with immediate effect. The disposal policy and procedures document was updated after the inspection.

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.

Review of a sample of the medicines administration records showed that these were well maintained and residents were being administered their medicines. They included the variable dose administered, alerts for dates of injections and the use of separate administration charts for inhalers, laxatives and analgesics. These are examples 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 appropriately recorded.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out on all aspects of medicines management such as medicine records, different formulations of medicines and high risk medicines. Areas of good practice were acknowledged and included ensuring the date of opening was recorded on all medicines to facilitate the audit process. The audits completed during this inspection showed that medicines had been administered as prescribed and safe systems were in place to monitor administration.

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 admission process for residents new to the home or returning to the home after receiving hospital care was reviewed. Staff advised that robust arrangements were in place to ensure that they were provided with written confirmation of the resident's medicine regime at or prior to admission and details were updated on the resident's records by two trained staff, to ensure accuracy. Systems were in place to follow up on any discrepancies in a timely manner, to ensure that the correct medicines were available for administration.

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. A robust auditing system helps staff identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported. The manager advised that there had been no medicine related incidents.

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. In addition, detailed policies and procedures should be in place and readily available for staff reference.

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 robust arrangements are in place for the safe management of medicines. Staff are knowledgeable and are familiar with the residents' medicine regimes. The auditing processes are effective in ensuring that residents are being administered their medicines as prescribed, records are kept up to date and are well maintained, and medicines are stored safely and securely. No new areas for improvement were identified.

Thanks are given to the staff, residents and their representatives for their assistance with this inspection.

7.0 Quality Improvement Plan/Areas for Improvement

No new areas for improvement were identified at this inspection. One area for improvement has been carried forward for review at the next inspection and is detailed in the QIP.

Findings of the inspection were discussed with Mrs Emeliza Insauriga, Registered Manager, as part of the inspection process and can be found in the main body of the report.

	Regulations	Standards
Total number of Areas for Improvement	1*	0

*One area for improvement as detailed in the QIP is carried forward for review at the next inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005	
Area for Improvement 1 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** With immediate effect (from 23 November 2020)	The registered person shall ensure that RQIA is informed of all notifiable accidents/ incidents appropriately.
	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: 5.1

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