The Regulation and Quality Improvement Authority

Inspection Report

25 May 2021

The Graan Abbey

Type of service: Residential Care Home
Address: Derrygonnelly Road, Enniskillen,
BT74 5PB
Telephone number: 028 6632 7000

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: Carewell Homes Ltd **Responsible Individual:** Mrs Carol Kelly	**Registered Manager:** Mrs Heather Lyttle **Date registered:** 21 October 2019
Person in charge at the time of inspection: Mrs Heather Lyttle	**Number of registered places:** 27
Categories of care: Residential Care (RC): I – old age not falling within any other category PH – physical disability other than sensory impairment MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 9
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 27 residents. This home is situated in the same building as The Graan Abbey Nursing Home.	

2.0 Inspection summary

An unannounced inspection took place on 25 May 2021 between 11.15am and 2.00pm.

The inspection was carried out by a pharmacist inspector and focused on medicines management within the home.

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

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

4.0 What people told us about the service

The inspector met with the manager and senior carer. 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 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.

In order to reduce the footfall throughout the home, the inspector did not meet with any residents during the inspection. However, 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?

This is the first medicines management inspection of the home.

The last inspection to this residential care home was undertaken on 20 October 2020 by a care inspector. No areas for improvement were identified.

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 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, for example, 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. Directions for use were clearly recorded on the personal medication records and records of administration were maintained. The reason for and outcome of administration were recorded. Staff on duty 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. Care plans directing the use of these medicines were in place.

The management of pain was discussed. Care plans and accurate records of prescribing and administration were in place. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required.

A small number of residents self-administer some of their medicines. The senior carer advised that a record of ordering and transfer to the residents was maintained. However, this was not recorded on the personal medication records and care plans were not in place. This was addressed during the inspection. A record of the transfer of medicines to the residents for self-administration was maintained which enabled staff to monitor ongoing capability.

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 as needed.

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.

The sample of medication administration records reviewed were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for review/audit.

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.

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 audits completed during this inspection showed that residents had been given their medicines as prescribed.

The medicine cups used to administer medicines to residents were labelled as single use. Therefore, they should be discarded after each use. The senior carer advised that the cups are washed after use and then reused. This matter was discussed with the manager who gave an assurance that this practice would stop.

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. The senior carer advised that robust arrangements were in place for new admissions to ensure that staff were provided with an accurate list of prescribed medicines and this was shared with the GP and community pharmacist.

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.

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 assessment. Records of staff training in relation to medicines management were available for inspection.

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.

No areas for improvement were identified. We can conclude that overall the residents were being administered their medicines as prescribed.

We 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 areas for improvement being identified. Findings of the inspection were discussed with Mrs Heather Lyttle, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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