

Inspection Report

23 May 2024



Ashbrook Care Home

Type of service: Residential Care Home

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www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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: Ashbrook Home Ltd Responsible Individual: Mr Marcus James Mulgrew	Registered Manager: Ms Kathleen Buccat, registered manager
Person in charge at the time of inspection: Ms Kathleen Buccat, registered manager	Number of registered places: 9
Categories of care: Residential Care (RC): DE – dementia	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: Ashbrook Care Home is a residential care home registered to provide health and social care for up to 9 residents. There is a nursing home in the same building and the manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 23 May 2024, from 10.30am to 12.45pm. This was completed by a pharmacist inspector. The inspection focused on medicines management within the home and also assessed progress with the area for improvement identified at the last inspection. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

Review of medicines management found that safe systems were in place for the management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. One new area for improvement was identified in relation to monitoring and recording the temperature of the medicines storage area.

Whilst an area for improvement was identified, RQIA can conclude that overall, the residents were being administered their medicines as prescribed.

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

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. The inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. Discussions took place with staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with senior care staff, the general manager and the manager. Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs.

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

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 received by RQIA.

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 care inspection on 26 June 2023		
Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2011		Validation of compliance
Area for Improvement 1 Ref: Standard 23.4 Stated: First time	The registered person shall ensure all staff receive up-to-date training in dysphagia.	Met
	Action taken as confirmed during the inspection: All staff had received up-to-date training in dysphagia. Records were maintained and 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 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 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 were written and updated to state 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. This is good practice.

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 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 distressed reactions was reviewed. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain. Records included the reason for and outcome of each administration.

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 and reviewed regularly.

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. All staff should have the necessary training to ensure that they can meet the needs of the resident.

The management of thickening agents was reviewed. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

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

Medicine 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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located. The temperature of medicines storage area was not monitored or recorded. This is necessary to ensure that medicines are stored appropriately as per the manufacturers recommendations. An area for improvement was identified.

Satisfactory arrangements were in place for the safe disposal of medicines.

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.

A sample of the medicines administration records was reviewed. Most of the records were found to have been fully and accurately completed. Staff were reminded that two staff must check and sign handwritten medicine administration recorded to verify that they are accurate. The manager agreed that this would be monitored.

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 should be recorded in the controlled drug record book. There were mostly satisfactory arrangements in place for the management of controlled drugs. However, for a small number of controlled drugs which had been disposed of/transferred, balances had not been brought to zero; this was discussed for corrective action and monitoring.

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 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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new residents or residents returning from hospital. Written confirmation of the resident's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

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 audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. The 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 audits completed at the inspection indicated that medicines were being administered 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 they are supported.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal.

6.0 Quality Improvement Plan/Areas for Improvement

One new area for improvement has been identified where action is required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	0	1

The area for improvement and details of the Quality Improvement Plan were discussed with Mrs Kathleen Buccat, Registered Manager, as part of the inspection process. The timescale for completion commences from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022	
Area for improvement 1 Ref: Standard 32 Stated: First time To be completed by: Immediate and ongoing (23 May 2024)	<p>The registered person shall ensure that the temperature of the medicines storage area is monitored and recorded daily and that appropriate action is taken if the temperature recorded exceeds 25°C.</p> <p>Ref: 5.2.2</p> <p>Response by registered person detailing the actions taken: The temperature of the medication storage area is monitored and recorded each day by a member of staff to ensure the temperature remains below 25C to allow safe storage of medication at all times.</p>

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