The Regulation and Quality Improvement Authority

Inspection Report

17 September 2021

Rylands

Type of service: Residential Care Home
Address: 11 Doagh Road, Kells, Ballymena, BT42 3LZ
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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: Rylands **Responsible Individuals:** Mr Trevor Duncan and Mrs Karen Duncan	**Registered Manager:** Mrs Valerie Rutherford **Date registered:** 6 June 2018
Person in charge at the time of inspection: Mrs Kripa Sulabha (Deputy Manager)	**Number of registered places:** 14
Categories of care: Residential Care (RC): 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:** 13
Brief description of the accommodation/how the service operates: This is a residential care home that provides care for up to 14 residents. This home is situated on the same site as Rylands nursing home.	

2.0 Inspection summary

An unannounced inspection took place on 17 September 2021, from 11.00am to 2.10pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

There was evidence that robust arrangements were in place for the safe management of medicines and residents were administered their medicines as prescribed.

Staff were knowledgeable about the residents' medicines and records were well maintained. A quality improvement plan did not result from this 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 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. 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.

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 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 had completed and returned questionnaires to RQIA. Their responses were positive indicating they were "very satisfied" with the care provided in 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?

No areas for improvement were identified at the last care inspection (14 May 2020) and last medicines management inspection (20 August 2018).

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 at medication reviews and 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 verified and signed the personal medication records when they were written and updated, to 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. 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, warfarin, self-administration etc. Following a review of residents' files, there was evidence that detailed medicine related care plans were in place; they were up to date and were reviewed monthly.

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 worked closely with each resident's GP and the community pharmacist to ensure 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 controlled drugs cabinet was in use.

In relation to medicines which require cold storage, for example, overstock of insulin pens, eye drops, these were stored in a locked box in the domestic refrigerator and only accessed by authorised staff. Daily temperature checks were completed by kitchen staff. The temperature records indicated that the minimum temperature was occasionally below the recommended lower limit of 2^{o}C. The deputy manager advised that a new thermometer and separate temperature chart would be put in place with immediate effect and would be monitored as part of the daily medicine audit process.

The disposal arrangements for medicines were reviewed. Discontinued medicines were safely returned to the community pharmacy for disposal and records maintained. However, controlled drugs were denatured using a denaturing kit before return to the community pharmacy. In residential care homes, controlled drugs do not require denaturing. This was reviewed in relation to the home's controlled drugs policy and disposal of medicines policy. It was agreed that the wording would be made clearer and the issue highlighted to staff for corrective action from the date of 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 medicine records indicated that they had been fully and accurately completed. Residents had received their medicines as prescribed. Systems were in place to ensure that these records were filed appropriately each month.

Controlled drugs are medicines which are subject to strict legal controls, record keeping and legislation. They commonly include strong pain killers. A review of the controlled drugs records indicated that they had been well maintained and stocks were checked at each shift change.

Management and staff audited medicine administration on a regular basis within the home. Several audits were carried out and included a variety of medicine formulations. The date of opening was recorded on all medicines so that they could be easily audited and a running stock balance was maintained for specific medicines. These are areas of good practice. The audits completed at the inspection showed that medicines were administered as prescribed.

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. Written confirmation of the resident's medicine regime was received at or prior to admission and details updated on the resident's records. 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 staff can learn from the incident.

The audit system in place helps staff to identify if a medicine related incident has occurred. There had been no medicine related incidents reported to RQIA since registration of the home in 2018. 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.

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. Records of staff induction, training and competency in relation to medicines management were maintained.

Medicine related policies were in place and located in the treatment room for staff reference. (See also 5.2.2)

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 with respect to medicines management.

The outcome of this inspection concluded the residents were administered their medicines as prescribed by their GP. There were robust systems in place to ensure medicine related records were updated in a timely manner and detailed medicine related care plans were in place to direct the care of the residents. Based on the inspection findings and discussions held, RQIA is 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 management team.

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 Kripa Sulabha, Deputy Manager, as part of the inspection process and can be found in the main body of the report.

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