Inspection Report

4 April 2023

Kilwee Care Home

Type of service: Residential Care Home
Address: 42f Cloona Park, Dunmurry, BT17 0HH
Telephone number: 028 9061 8703

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: Merit Retail Limited **Responsible Individual:** Mr Jarlath Conway	**Registered Manager:** Ms Deborah Campbell **Date registered:** 3 June 2021
Person in charge at the time of inspection: Ms Deborah Campbell	**Number of registered places:** 20
Categories of care: Residential Care (RC): DE – dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 19
Brief description of the accommodation/how the service operates: Kilwee Care Home is a residential care home which is registered to provide care for up to 20 residents. The nursing home is located in the same building.	

2.0 Inspection summary

An unannounced inspection took place on 4 April 2023, from 10.00am to 2.00pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

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.

The areas for improvement identified at the last care inspection will be followed up at the next inspection.

Review of medicines management found that residents were being administered their medicines as prescribed. There were arrangements for auditing medicines and medicine records were well maintained. Arrangements were in place to ensure that staff were trained and competent in medicines management. One area for improvement in relation to the management of distressed reactions was identified.

Based on the inspection findings and discussions held, RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is will led by the management team in relation to medicines management.

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 the home was 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. To complete the inspection, the following were 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. The inspector spoke 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 one care assistant, one senior carer and the manager.

Staff were warm and friendly and it was evident from discussions that they knew the residents well.

The staff members spoken with expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

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. No questionnaires had been received by RQIA at the time of issuing this report. .

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 inspection on 19 December 2022		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 19 (1) (a) Schedule 3 (k) **Stated:** First time	The registered person shall ensure a contemporaneous record of all care and services provided to residents is maintained on a daily basis. This should include a record of the resident's condition and any other treatment or interventions. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**
Area for Improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the following: • donning and doffing of personal protective equipment • appropriate use of personal protective equipment • staff knowledge and practice regarding hand hygiene. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next 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 residential 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 may 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 or hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with safe practice, a second member of staff had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. A small number of obsolete personal medication records were available in the medicines file. Staff were reminded that obsolete personal medication records should be cancelled and archived to ensure that they are not referred to in error.

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 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 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 for five residents. 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, infection or constipation. Directions for use were clearly recorded on the personal medication records. Records of administration and the reason for and outcome of administration were recorded. However, for three residents regular use had not been referred to the prescriber for review. In addition, care plans were not in place for two residents. An area for improvement was identified.

The management of pain was reviewed. Staff were familiar with how each resident expressed their pain and that pain relief was administered when required. Care plans and pain assessments 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. Speech and language assessment reports and care plans were 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?

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.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. The daily records showed that the refrigerator thermometer had been out of order since 30 March 2023. This had been reported and was addressed during the inspection. Staff were reminded that liquid antibiotics must be disposed of in accordance with the manufacturers' recommendations.

Arrangements were in place for the safe disposal of medicines. However, staff were reminded that controlled drugs should not be denatured prior to returning to the community pharmacy. The manager advised that this would be actioned immediately and the controlled drugs standard operating procedures would be updated and shared with staff. Due to these assurances an area for improvement was not identified in the quality improvement plan.

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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. The records had been completed in a satisfactory manner.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The records of receipt, administration and disposal of controlled drugs were maintained to the required standard in a controlled drug record book.

Management and staff audited medicine administration on a regular basis within the home. In addition, running stock balances were maintained for medicines which were not supplied in the monitored dosage system. The majority of audits completed at the inspection indicated that medicines were administered as prescribed. It was agreed that the areas for improvement identified and discussed at this inspection would be included in the audit process.

A small number of residents have their medicines administered in food/drinks to assist administration. This had been authorised by the prescribers and care plans detailing how the residents like to take their medicines were in place.

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 residents new to the home or 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 and medicines administered as prescribed.

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.

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.

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. 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. A written record was completed for induction, annual update training and competency assessment.

The manager advised that the findings of this inspection would be shared with all staff for ongoing improvement.

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 2021.

	Regulations	Standards
Total number of Areas for Improvement	2*	1

* The total number of areas for improvement includes two that have been carried forward for review at the next inspection.

The new area for improvement and details of the Quality Improvement Plan were discussed with Ms Deborah Campbell, Registered Manager, as part of the inspection process. The timescale for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005	
Area for Improvement 1 **Ref:** Regulation 19 (1) (a) Schedule 3 (k) **Stated:** First time **To be completed by:** Immediate action required (19 December 2022)	The registered person shall ensure a contemporaneous record of all care and services provided to residents is maintained on a daily basis. This should include a record of the resident's condition and any other treatment or interventions. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Area for Improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** Immediate action required (19 December 2022)	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the following: • donning and doffing of personal protective equipment • appropriate use of personal protective equipment • staff knowledge and practice regarding hand hygiene. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Action required to ensure compliance with Residential Care Homes Minimum Standards 2021	
Area for improvement 1 **Ref:** Standard 6 **Stated:** First time **To be completed by:** Immediate action required (4 April 2023)	The registered person shall review the management of distressed reactions to ensure that care plans are in place and regular use is referred to the prescriber for review. Ref: 5.2.1 **Response by registered person detailing the actions taken:** Care plans were not in place as these were residents who had been newly prescribed chemical restraint medication. Care plans were formulated on day of inspection. The three residents who were using PRN medications regularly were under constant review from psychiatry of old age and GP's. GP's were contacted post inspection and did not wish to change directions as current regime is deemed to be sufficiently meeting residents needs.

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