The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **SENSE Short Break Service**

Provider: **SENSE**

Date of Inspection: **9 January 2025**

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:	SENSE
Responsible Individual:	Mr Martin Walls
Registered Manager:	Mr Patrick Black
Service Profile: SENSE Short Break Service is a residential care home registered to provide residential care for up to three residents. The home is situated on the ground floor of the building and residents have access to a communal lounge and dining room.	

2.0 Inspection summary

An unannounced inspection took place on 9 January 2025, from 10.15am to 12.10pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Arrangements were in place to ensure that medicines were stored securely during each short break. Medicine records and medicine related care plans were well maintained. However, improvements were necessary in relation to the management of controlled drugs and medicines management audits.

Whilst areas for improvement were identified, there was evidence residents were being administered their medicines as prescribed.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, and new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

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

3.0 The inspection

3.1 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 against the regulations and standards, 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from residents, relatives, staff or the commissioning Trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

3.2 What people told us about the service and their quality of life

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.

Staff advised that they were familiar with how each resident liked to take their medicines. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

RQIA did not receive any completed questionnaires or responses to the staff survey following the inspection.

3.3 Inspection findings

3.3.1 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.

The home provides short break care for residents. Each resident is registered with a GP and medicines are supplied by the resident's next of kin for each short break.

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 sample of personal medication records reviewed were accurate and up to date. In line with best practice, a second member of staff should check and sign the personal medication records when they were written and updated to confirm that they are accurate. A number of second verification signatures were missing on the records reviewed. This was highlighted to the manager for corrective action and ongoing vigilance.

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.

The management of distressed reactions and epilepsy was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed during the recent short break.

3.3.2 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.

Staff advised that systems were in place to ensure that sufficient medicines were supplied on admission for each short break. Records reviewed showed that medicines were available for administration when residents required them.

The medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised. There were no medicines in the home on the day of the inspection. Staff advised that medicines belonging to each resident were stored securely so that they can be easily located during each short break. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage.

A review of recent admissions indicated that one controlled drug had not been stored in the controlled drugs cabinet and subsequently records of receipt and administration were not recorded in a controlled drugs record book. See Section 3.3.3.

Satisfactory arrangements were in place for the return of medicines at the end of each short break.

3.3.3 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. T he records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

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. Review of the records indicated that one controlled drug had not been recorded in the controlled drug record book, stored in the controlled drug cabinet or reconciled at handover, as staff were unaware that it was a Schedule 2 controlled drug. The person in charge advised that a list of controlled drugs would be made available for staff. An area for improvement was identified.

The audits completed by management and staff had not identified the issues identified at this inspection including issues with storage and record keeping for controlled drugs and missing verification signatures on personal medication records. The manager should implement a robust audit system which covers all aspects of the management and administration of medicines including those identified. Any shortfalls identified should be detailed in an action plan and addressed. An area for improvement was identified.

3.3.4 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 at each admission for respite care. Written confirmation of prescribed medicines was obtained from the GP at or prior to the resident's first admission and a personal medication record was written. Next of kin are aware that written confirmation from the prescriber is required for any subsequent medication changes. The personal medication record is checked with the medicines supplied at each admission; any anomalies are followed up with the prescriber prior to administration.

3.3.5 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 incident which had been reported to RQIA since the last inspection was discussed. There was evidence that the incident had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

3.3.6 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 they staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date 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.

Records of staff training in relation to medicines management, epilepsy awareness, buccal midazolam were available.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	6*

* the total number of areas for improvement includes four which were carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with the person in charge, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Care Standards for Residential Homes, December 2022	
Area for improvement 1 **Ref:** Standards 31, 32 & 33 **Stated:** First time **To be completed by:** 9 January 2025	The registered person shall ensure that controlled drugs subject to safe custody requirements are stored in the controlled drug cupboard, recorded in the controlled drug record book and reconciled on each occasion when responsibility for safe custody is transferred. Ref: 3.3.2 & 3.3.3
	Response by registered person detailing the actions taken: action completed and drug record book put in place 10 January 2025
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 9 January 2025	The registered person shall ensure that audits covering all aspects of medicines management are regularly carried out. Any shortfalls identified should be detailed in an action plan and addressed. Ref: 3.3.3
	Response by registered person detailing the actions taken: monthly audits now being carried out by and signed off by RCM
Area for improvement 3 **Ref:** Standard 23 **Stated:** First time **To be completed by:** With immediate effect (3 November 2023}	The responsible individual shall ensure a record is kept in the home of training completed by all staff working in the home and the completion of food hygiene.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0

Area for improvement 4 **Ref:** Standard 24 **Stated:** First time **To be completed by:** 30 December 2023	The responsible individual shall ensure all staff are supervised and their performance appraised to promote the delivery of quality care and services.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0
Area for improvement 5 **Ref:** Standard 29 **Stated:** First time **To be completed by:** With immediate effect (3 November 2023}	The responsible individual shall ensure that there is an up to date fire risk assessment in place at all times.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0
Area for improvement 6 **Ref:** Standard 20.10 **Stated:** First time **To be completed by:** 30 December 2023	The responsible individual shall ensure audits are recorded in sufficient detail to drive improvement.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0

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The Regulation and Quality Improvement Authority

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