The Regulation and Quality Improvement Authority

# Inspection Report

## 1 September 2022

# Killynure House

Type of service: Residential Care Home
Address: 26 Church Road, Carryduff, BT8 8DT
Telephone number: 028 9504 2960

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

## 1.0 Service information

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| **Organisation/Registered Provider:**<br>Belfast Health and Social Care Trust<br><br>**Responsible Individual:**<br>Dr Catherine Jack | **Registered Manager:**<br>Mrs Helen Taggart (Acting) |
| **Person in charge at the time of inspection:**<br>Mr Ola Johnston, Deputy Manager | **Number of registered places:**<br>40<br><br>The home is approved to provide care on a day basis for two persons in DE category of care Monday to Sunday inclusive. |
| **Categories of care:**<br>Residential Care (RC):<br>DE – dementia | **Number of residents accommodated in the residential care home on the day of this inspection:**<br>19 |
| **Brief description of the accommodation/how the service operates:**<br><br>Killynure House is a residential care home which is registered to provide care for up to 40 residents. | |

## 2.0 Inspection summary

An unannounced inspection took place on 1 September 2022, from 10.30am to 3.10pm. The inspection was completed by a pharmacist inspector.

The inspection focused on medicines management within the home. Following discussion with the aligned care inspector it was agreed that the area for improvement identified at the last care inspection would be followed up at the next 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 the majority of medicines were being administered as prescribed and medicines were stored securely. However, areas for improvement were identified in relation to governance and audit, the management of controlled drugs and care planning in relation to distressed reactions and adding medicines to food/drink to assist administration.

Based on the inspection findings and assurances provided, RQIA are 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.

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 the one resident, the senior carer, the deputy manager and the assistant services' manager.

Staff were warm and friendly and it was evident from discussions that they knew the residents well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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. 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 inspection on 25 August 2022 | | |
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| **Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005** | | **Validation of compliance** |
| **Area for improvement 1**<br><br>**Ref:** Standard N10<br><br>**Stated:** First time | The registered person shall ensure that resident/staff call points are provided in every toilet in the home.<br><br>**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 best 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. Staff were reminded that obsolete personal medication records should be cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions 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. 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. Records of administration which included the reason for and outcome of administration were recorded. However, when more than one medicine was prescribed the personal medication records and care plans did not specify which medicine should be used first line and second line. An area for improvement was identified.

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 which contained enough information to direct the required care were in place.

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 which included the recommended consistency level were maintained.

A number of residents have their medicines crushed and added to food/fluids to assist administration; this had been discussed and agreed to be in the residents' best interests and authorised by the prescribers. Staff confirmed that the pharmacist had been consulted to provide guidance on the suitability of crushing the medicines and adding to food/drink. However, care plans were not in place for all residents and those that were in place did not provide details of how each medicine should be administered. An area for improvement was identified.

### 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. However, some out of date eye preparations remained in use. The senior carer advised that this had been an oversight as they are usually replaced at the end of each four week cycle. New supplies were brought into use at the inspection.

Medicines were returned to the community pharmacy for disposal and records maintained. Staff advised that controlled drugs in Schedule 2, 3 and 4 Part (1) were denatured in the home prior to return to pharmacy. In residential care homes controlled drugs should not be denatured. The deputy manager advised that this practice would cease from the date of the inspection. The Standard Operating Procedure for the return/disposal of controlled drugs should be reviewed and updated to ensure that controlled drugs are disposed of in accordance with The Safer Management of Controlled Drugs, A Guide to Good Practice in Primary Care (2013). An area for improvement was identified.

### 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 mostly satisfactory manner. Staff were reminded that any hand-written medication administration records should be verified and signed by two staff to ensure accuracy of transcription.

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 had not been maintained to the required standard in a controlled drug record book. A number of missed entries were observed and the running stock balances were not clearly maintained. An area for improvement was identified.

Management and staff audited the administration of a small number of medicines each week. The majority of audits completed at the inspection indicated that medicines were administered as prescribed. However, some audits could not be completed as dates of opening had not been recorded. In addition discrepancies were identified in the administration of one inhaled medicine, one supply of mirtazapine and three supplies of memantine. The registered person must implement a robust audit system which covers of aspects of the management and administration of medicines, including those identified at this inspection. An area for improvement was identified.

### 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 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. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

### 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.

As detailed in Section 5.2.3 the auditing system was not robust and hence medication incidents may not be identified. The need for a robust audit system which covers all aspects of medicines management and administration is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff.

### 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. Update training on the management of medicines was provided every two years. Competency assessments were completed following induction and annually thereafter. Records of staff training and competency assessment were available for inspection.

The assistant services' manager provided assurances that the findings of the inspection would be discussed with all staff for learning.

## 6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes (Northern Ireland) 2005 and Residential Care Homes Minimum Standards 2021.

| | Regulations | Standards |
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| **Total number of Areas for Improvement** | 2 | 4* |

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Ola Johnston, Deputy Manager, and Ms Ashlyn Foster, Assistant Services' Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

## Quality Improvement Plan

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| **Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005** | |
| **Area for improvement 1**<br><br>**Ref:** Regulation 13 (4)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate and ongoing | The registered person shall ensure that records for the receipt, administration and disposal of controlled drugs are accurately maintained in the controlled drug record book.<br><br>Ref: 5.2.3 |
| | **Response by registered person detailing the actions taken:**<br>The Monthly Manager's Medicine Audit Tool includes Auditing of the Controlled Drug Record Book. Auditing of the Controlled Drug Record Book has been increased to weekly. Management of Medications is on the agenda at all staff meetings and discussed in individual supervision sessions with staff. |
| **Area for improvement 2**<br><br>**Ref:** Regulation 13 (4)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate and ongoing | The registered person shall implement a robust audit system which covers all aspects of the management and administration of medicines. Any shortfalls identified should be detailed in an action plan and addressed.<br><br>Ref: 5.2.3 & 5.2.5 |
| | **Response by registered person detailing the actions taken:**<br>The Monthly Manager's Medication Audit tool was not provided on the day of inspection. This audit tool incorporates Regulation 13 (4) and RQIA Standards 30, 31, 32, 33 and the individual criteria under these standards. The audit tool includes a column to record required actions and has been reviewed and updated to provide an action plan template to ensure required actions are formally recorded and followed up. |
| **Action required to ensure compliance with Residential Care Homes Minimum Standards 2021** | |
| **Area for improvement 1**<br><br>**Ref:** Standard N10<br><br>**Stated:** First time<br><br>**To be completed by:**<br><br>1 November 2022 | The registered person shall ensure that resident/staff call points are provided in every toilet in the home. |
| | **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.**<br><br>Ref: 5.1 |

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| **Area for improvement 2**<br><br>**Ref:** Standard 6<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate and ongoing | The registered person shall review the management of distressed reactions as detailed in the report.<br><br>When more than one medicine is prescribed, the personal medication records and care plans should provide details on which medicine should be used first line and second line.<br><br>Ref: 5.2.1 |
| | **Response by registered person detailing the actions taken:**<br>The care plans and personal medication records of those residents who are prescribed more than one medication have been reviewed and updated. The personal medication record now provides clear details on which medication is to be used first line and which is to be used second line. This information has also been incorporated into the resident's care plan. This information has been confirmed with the prescriber.<br>Alternative strategies in the management of distressed behaviours are clearly outlined in the care plan to include engagement of the resident and distraction techniques. The care plan also includes the need for staff to consider other contributing factors in relation to distressed behaviours - to include communication of pain or discomfort. |
| **Area for improvement 3**<br><br>**Ref:** Standard 6<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate and ongoing | The registered person shall review the management of adding medicines to food/drinks to assist administration.<br><br>Care plans should provide details on how each medicine is to be administered.<br><br>Ref: 5.2.1 |
| | **Response by registered person detailing the actions taken:**<br>All resident care plans have been reviewed and updated to provide specific details on how each medication is to be administered when being added to food / drinks to assist administration. The care plan indicates the residents' preferences regarding food and drinks. The care plan includes details regarding the rationale for adding medicines to food / drinks. |
| **Area for improvement 4**<br><br>**Ref:** Standard 30<br><br>**Stated:** First time<br><br>**To be completed by:**<br>1 November 2022 | The registered person shall review and update the Standard Operating Procedure for the return/disposal of controlled drugs.<br><br>Ref: 5.2.2 |
| | **Response by registered person detailing the actions taken:**<br>The practice of use of a destruction kit which had been provided by community pharmacy was ceased with immediate effect on the day of the inspection. The Standard Operating Procedure in place has been reviewed and updated to include - |

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| | -Controlled drugs, which are no longer required by residents in the registered residential care home, are permitted to be returned to a community pharmacy for disposal.<br>-The transfer of controlled drugs to a pharmacy for disposal must be documented in the home's controlled drug record book. Details required include: • Form of controlled drug • Quantity of controlled drugs • Date and time of transfer • Signature of authorised person.<br>-It is good practice that the community pharmacist receiving the controlled drugs for the purpose of disposal should also sign the registered residential home's controlled drug record book at the time of transfer. |

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