Inspection Report
18 May 2021

Laurelhill House

Type of service: Residential Care Home
Address: 1a Ballymacash Park, Lisburn, BT28 3EX
Telephone number: 028 9260 2116

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: South Eastern Health and Social Care Trust **Responsible Individual:** Mr Seamus McGoran (Acting)	**Registered Manager:** Ms Sue Curry **Date registered:** 31 August 2018
Person in charge at the time of inspection: Ms Sue Curry	**Number of registered places:** 30
Categories of care: Residential Care (RC): DE – dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 26
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 30 residents living with dementia.	

2.0 Inspection summary

An unannounced inspection took place on 18 May 2021, between 10.25am and 1.40pm. The inspection was completed by a pharmacist inspector.

This inspection focused on medicines management within the home.

Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last care inspection would be followed up at the next care inspection.

Although we identified two areas for improvement, we can conclude that overall, the residents were being administered their medicines as prescribed. Based on the inspection findings and discussions held; we are satisfied that this service is providing safe and effective care in a caring and compassionate manner regarding the management of medicines.

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. To complete the inspection: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines were reviewed.

During the inspection the inspector:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- medicine receipt and disposal
- controlled drug records
- care plans related to medicines management
- governance and audit
- staff training and competency
- medicine storage temperatures
- RQIA registration certificate

4.0 What people told us about the service

The inspector met with the senior care assistant and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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

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. They spoke highly of the support given by management and the communication within the home.

Feedback methods included a staff poster to facilitate online feedback 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, one relative questionnaire had been returned. Positive feedback was included and the respondent indicated they were very satisfied with the care received. No staff responses were received within the allocated timescale.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 6 February 2021		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 30 (1) **Stated:** First time	The registered person shall ensure that all events are reported to RQIA within the agreed timeframe.	**Carried forward to the next care inspection**
	Medicines incidents had been reported appropriately since the last care inspection (see Section 5.2.5). **Action required to ensure compliance with this regulation was not fully reviewed as part of this inspection and this is carried forward to the next care inspection.** .	
Area for Improvement 2 **Ref:** Regulation 29 (2) **Stated:** First time	The registered person shall ensure that the visits by the registered provider are completed each month.	**Carried forward to the next care inspection**
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next care inspection.	
Area for Improvement 3 **Ref:** Regulation 29 (3) (c) **Stated:** First time	The registered person shall ensure that the visits by the registered provider contain the following information: • the time of commencement and finish of the visit • an accurate and comprehensive review of reporting of accidents and incidents	**Carried forward to the next care inspection**
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next care 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 will 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 e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were mostly 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 provide a double check that they are accurate. Some minor discrepancies were identified and highlighted to staff for immediate attention.

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, 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 on 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 the management of 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. Directions for use were clearly recorded on the personal medication records; however care plans directing the use of these medicines were not available. An area for improvement was identified. It was acknowledged that these medicines were not in frequent use, however, although a record was in place, the reason for and outcome of administration were not recorded in a consistent manner. The manager agreed to discuss and implement a robust recording system with staff.

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 as directed when required.

Care plans were in place when residents required insulin to manage their diabetes.

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. It was advised that to prevent excess stock arising, stock levels of medicines should be carefully reviewed before reordering. The manager agreed to discuss this with staff and ensure stock levels are monitored.

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 medicine refrigerator and controlled drugs cabinet were available for use as needed.

The disposal arrangements for medicines were reviewed. Discontinued medicines were returned to the community pharmacy for disposal and records maintained.

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. These records were found to have been mostly fully and accurately completed. The records were filed once completed and were readily retrievable for review/audit. However, handwritten additions to these records had not been verified by two members of staff. This is necessary to confirm accuracy. An area for improvement was identified.

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 were recorded appropriately in controlled drug record books.

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 all 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.

Records for recent admissions to the home were reviewed. Robust arrangements were in place to ensure that staff were provided with a list of prescribed medicines and this was shared with the community pharmacist. Medicines had been accurately received into the home and administered in accordance with the most recent directions. There was evidence that staff follow up any discrepancies in a timely manner to ensure that the correct medicines are 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 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. This had been reviewed and discussed since the last care inspection.

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 during this inspection showed that residents had been given their medicines as prescribed.

The medicine cups used to administer medicines to residents were labelled as single use and should therefore be discarded after each use. The manager confirmed that these are disposed of after use. It was advised that spacer devices for use with inhaled medicines should be covered when stored on the medicines trolley, for infection prevention and control purposes. The manager agreed to implement this immediately.

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 use.

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. Policies and procedures were in place; these were under routine review at the time of the inspection.

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 regarding the management of medicines.

Two areas for improvement were identified and are detailed in the quality improvement plan; these relate to care plans to direct the management of distressed reactions and the verification of additions to medication administration records.

Whilst areas for improvement were identified in relation to safe and effective care, we can conclude that overall, the residents were being administered their medicines as prescribed. Based on the inspection findings and discussions held, we 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 manager regarding the management of medicines.

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

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Residential Care Home Regulations (Northern Ireland) 2005 and the Residential Care Homes Minimum Standards (2011).

	Regulations	Standards
Total number of Areas for Improvement	*3	2

* The total number of areas for improvement includes three which are carried forward for review at the next care inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Sue Curry, Registered Manager, 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 Residential Care Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 30 (1) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that all events are reported to RQIA within the agreed timeframe. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next care inspection.** Ref: 5.1
Area for improvement 2 **Ref:** Regulation 29 (2) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that the visits by the registered provider are completed each month. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next care inspection.** Ref: 5.1
Area for improvement 3 **Ref:** Regulation 29 (3) (c) **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that the visits by the registered provider contain the following information: • the time of commencement and finish of the visit • an accurate and comprehensive review of reporting of accidents and incidents **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next care inspection.** Ref: 5.1
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 25 May 2021	The registered person shall ensure that care plans are in place to direct care when medicines are prescribed to manage distressed reactions on a “when required” basis. Ref: 5.2.1 **Response by registered person detailing the actions taken:** Person-centred care plans have been put in place to meet this action requirement and will be audited as part of monthly supervision.

Area for improvement 2 **Ref:** Standard 31 **Stated:** First time	The registered person shall ensure that two staff verify and sign handwritten additions to medication administration records to confirm accuracy. Ref: 5.2.3
To be completed by: Immediate and ongoing	**Response by registered person detailing the actions taken:** Two staff signatures are in place to confirm medication is checked and verified to confirm accuracy. Medication Administration Records will be audited on a monthly basis to measure compliance.

Please ensure this document is completed in full and returned via the Web Portal

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