The Regulation and Quality Improvement Authority

# Inspection Report

## 9 November 2021

# Aaron House

Type of Service: Residential Care Home
Address: 40 Rosneath Gardens, Ballyoran, Dundonald, Belfast, BT16 1UN
Telephone number: 028 9041 0045

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>Presbyterian Council of Social Witness<br><br>**Responsible Individual(s):**<br>Mr Lindsay Conway | **Registered Manager:**<br>Miss Isabella Harper<br><br>**Date registered:**<br>1 March 2017 |
| **Person in charge at the time of inspection:**<br>Miss Isabella Harper | **Number of registered places:**<br>16 |
| **Categories of care:**<br>Residential Care (RC):<br>LD – learning disability<br>LD(E) – learning disability – over 65 years | **Number of residents accommodated in the residential care home on the day of this inspection:**<br>14 |
| **Brief description of the accommodation/how the service operates:**<br>This is a residential care home registered to provide residential care for up to 16 residents with a learning disability. | |

## 2.0 Inspection summary

An unannounced inspection took place on 9 November 2021 from 10.15am to 1.15pm. The inspection was conducted by a pharmacist inspector and 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.

Review of medicines management found that residents were administered their medicines as prescribed. Medicines were securely stored and staff had the training needed to ensure that they were competent to manage medicines. One area for improvement in relation to handwritten medicine administration records was identified.

## 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. The inspector also spoke to 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 two care staff and the manager. Staff were warm and friendly and it was evident from their interactions that they knew the residents well.

Staff spoken to said that they had the appropriate training to look after residents and meet their needs. They said the COVID-19 pandemic and current staffing levels had impacted on the morale of staff. This was raised with the manager who was aware of the impact on staff morale and advised that measures were being taken to improve morale.

Feedback methods included a staff poster and paper questionnaires which were provided to the registered 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, five completed questionnaires were returned by family representatives of residents. Responses ranged from satisfied to very satisfied in relation to the standard of care provided by Aaron House. One respondent stated staff in the home were "so good" but could do with more support.

## 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 29 April 2021 | | |
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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**: Regulation 20(1)(a)<br><br>**Stated:** First time | The registered person shall ensure that the planned staffing is consistently provided to ensure there is sufficient staff on duty to meet the needs of the residents.<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** |
| **Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011** | | **Validation of compliance summary** |
| **Area for improvement 1**<br><br>**Ref**: Standard 25.2<br><br>**Stated:** First time | The registered person shall ensure that dependency assessments are reviewed to ensure that level of assistance required from staff is accurately recorded.<br><br>**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.** | **Carried forward to the next inspection** |
| **Area for improvement 2**<br><br>**Ref**: Standard 25.6<br><br>**Stated:** First time | The registered person shall ensure that the duty rota accurately reflects the staff working on each shift; this will include agency staff.<br><br>**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.** | **Carried forward to the next inspection** |

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| **Area for improvement 3**<br><br>**Ref**: Standard 23.1<br><br>**Stated:** First time | The registered person shall ensure that the record of induction is fully completed and signed by both the person inducting and the inductee.<br><br>**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.** | **Carried forward to the next inspection** |
| **Area for improvement 4**<br><br>**Ref**: Standard 5.5<br><br>**Stated:** First time | The registered person shall ensure that risk assessments are reviewed more frequently.<br><br>**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.** | **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 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, for example, at medication reviews or hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date, with the exception of one discrepancy. In line with best practice, a second member of staff had checked and signed the personal medication records when they are written and updated to provide a double check that they were accurate. One personal medication record reviewed was not up to date with the most recent prescription. This was highlighted to the manager for immediate action. Staff were reminded that this could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional.

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 safe 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, self-administration 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. Care plans directing the use of these medicines were available; however these did not include the name of the prescribed medicine. The manager gave an assurance that this would be addressed following the inspection. These medicines were infrequently administered to residents.

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.

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 for three residents was reviewed. A speech and language assessment report and care plan was 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?

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.

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 organised so that medicines belonging to each resident could be easily located. Medicine trollies used to store resident's medications required cleaning to comply with infection, prevention and control (IPC). The manager gave an assurance that the trollies would be deep cleaned immediately following the inspection.

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. Most of the records were found to have been fully and accurately completed. Review of handwritten MARs identified only one staff member was involved in the writing of these records. When handwriting these records two trained staff should be involved and both should initial the entry to ensure 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 are recorded in a controlled drug record book. Satisfactory arrangements for the management of controlled drugs were in place.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out including daily running balances of all medicines. 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.

There had been no recent admissions to the home. However, the admission process for residents new to the home or returning to the home after receiving hospital care was discussed. Staff advised that robust arrangements were in place to ensure that they were provided with a list of medicines from the hospital and this was shared with the resident's GP and the community pharmacist. The need for the personal medication records to be accurately written/rewritten was reiterated.

### 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.

The audits completed at the inspection indicated medicines were being administered as prescribed.

### 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. A written record was completed for induction and competency assessments.

Records of staff training in relation to medicines management were available for 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 in relation to medicines management.

The outcome of this inspection identified one new area for improvement in relation to handwritten medicine administration records. Areas for improvement are detailed in the Quality Improvement Plan.

Whilst we identified one area for improvement, we can conclude that overall, the residents were being administered their medicines as prescribed. 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 manager in relation to medicines management.

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 were action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the Residential Care Homes Minimum Standards (2011).

| | Regulations | Standards |
|---|---|---|
| **Total number of Areas for Improvement** | 1* | 5* |

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Isabella Harper, Registered 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 20(1)(a)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Ongoing from the day of the inspection (29 April 2021) | The registered person shall ensure that the planned staffing is consistently provided to ensure there is sufficient staff on duty to meet the needs of the residents.<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.**<br><br>Ref: 5.1 |
| **Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)** | |
| **Area for improvement 1**<br><br>**Ref**: Standard 25.2<br><br>**Stated:** First time<br><br>**To be completed by:**<br>27 May 2021 | The registered person shall ensure that dependency assessments are reviewed to ensure that level of assistance required from staff is accurately recorded.<br><br>**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 |
| **Area for improvement 2**<br><br>**Ref**: Standard 25.6<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Ongoing from the day of the inspection (29 April 2021) | The registered person shall ensure that the duty rota accurately reflects the staff working on each shift; this will include agency staff.<br><br>**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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| | **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 |
| **Area for improvement 5**<br><br>**Ref**: Standard 31<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With immediate effect (9 November 2021) | The registered person shall ensure that all handwritten entries on medication administration records involve two trained staff to check that the information is accurate.<br><br>Ref: 5.2.3 |
| | **Response by registered person detailing the actions taken:**<br>All staff have been reminded about best practice, including ensuring that handwritten entries have two signatures.<br>The Medication Audit document has been updated and this includes question asking if PMRs have two signatures where information has been transcribed. Regular Medication Audits are undertaken. |

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

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