Inspection Report

12 August 2021

Drumary House

Type of service: Residential Care Home
Address: 44 Knockmore Road, Derrygonnelly, BT93 6GA
Telephone number: 028 6864 1736

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: Potensial Ltd **Responsible Individual:** Miss Nicky Stadames	**Registered Manager:** Mr Chris Coulter – not registered
Person in charge at the time of inspection: Mr Chris Coulter	**Number of registered places:** 17
Categories of care: Residential Care (RC): LD – learning disability LD(E) – learning disability – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 11
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 17 residents with a learning disability.	

2.0 Inspection summary

An unannounced inspection took place on 12 August 2021 between 10.30am and 1.45pm. This inspection was conducted by a pharmacist inspector.

This inspection focused on medicines management within the home.

Improvement was required in the management of medicines, particularly with regards to the completion of medicines records and the audit process. Further training in the management of medicines was required. Medicines were stored safely and securely and the audits completed during the inspection showed that medicines had been administered as prescribed.

The inspection also assessed progress with any areas for improvement identified since the last care and medicines management inspections.

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 was reviewed.

4.0 What people told us about the service

We met with two care staff 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 spoke highly of the support given by management.

In order to reduce footfall throughout the home, the inspector did not meet with any residents. 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, 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 last inspection?

Areas for improvement from the last inspection on 11 May 2021		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 29 **Stated:** Second time	The registered person shall ensure that reports produced following monthly monitoring visits are maintained within the home and accessible to residents, their representatives, staff and trust representatives. A copy of the report must also be forwarded to RQIA by the fourth day of each month until further notice.	**Carried forward to the next 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 inspection.	
Area for improvement 2 **Ref:** Regulation 27 (2) (b) (d) **Stated:** First time	The registered person shall ensure that the environmental issues identified during this inspection are addressed and that the home is decorated to an acceptable standard. With specific reference to: • door frames • skirting boards • paint work to walls.	**Carried forward to the next 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 inspection.	
Area for improvement 3 **Ref:** Regulation 15 (2) (a) (b) **Stated:** First time	The registered person shall review the management of residents' nutritional care needs to ensure that : • the recommended SALT dietary/fluid type is documented as per the IDDSI terminology within the residents' care records • relevant staff are aware of residents' dietary needs as per SALT recommendations and IDDSI terminology • relevant advice/referral is sought from SALT when/where there is a change to a residents swallowing ability .	**Met**
	Action taken as confirmed during the inspection: One resident was prescribed a modified diet. A speech and language assessment report was in place and was documented as per IDDSI terminology in the resident's care records. Staff spoken to were aware of the resident's dietary needs and completed records of the administration of thickening agents including the recommended consistency level.	

Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for improvement 1 **Ref:** Standard 6.6 time **To be completed by:** 11 July 2021	The registered person shall ensure that when the needs of a resident have changed, their care records are amended to accurately reflect these changes and any recommendations made by health care professionals. **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 **Ref:** Standard 21 **Stated:** Third and final time	The registered person shall ensure that policies and procedures are centrally indexed, are subject to a systematic three yearly review and are available for staff and residents where applicable. **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 3 **Ref:** Standard 20 **Stated:** Second time	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. With specific reference to: • Care records • Hand 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.**	**Carried forward to the next inspection**
Area for improvement 4 **Ref:** Standard 23.1 **Stated:** First time	The registered person shall ensure that initial induction and orientation records are maintained in the employees file for inspection. **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 5 **Ref:** Standard 32 **Stated:** First time	The registered person shall ensure that prescribed thickening agents are stored securely.	**Met**
	Action taken as confirmed during the inspection: Thickening agents were stored securely in the locked treatment room of the home.	

The last medicines management inspection of the home was on 21 September 2017. No areas for improvement were identified.

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, during medication reviews or hospital appointments.

A sample of these records reviewed were not up to date with the most recent prescription and some were incomplete. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. Updates to personal medication records had not been checked and signed by a second member of staff to ensure accuracy. It was evident that staff did not use these records as part of the administration of medicines process. Following the inspection, assurances were sought and received from the manager that all residents' personal medication records be reviewed and rewritten to reflect the most recent list of prescribed medicines. An area for improvement was identified.

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, 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 and care plans directing the use of these medicines were available in the medicines file. From the records observed, these medicines had not been required in recent times however staff were aware of the need to record the reason for and outcome of administration in the daily progress notes.

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 one resident 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?

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.

The disposal arrangements for medicines was 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. However, one medicine prescribed on a "when required" basis had been administered without any record of the administration. Full and contemporaneous records of the administration of medicines must be made at each medicine round. 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.

There had been no recent admissions to the home. However, we discussed the admission process for residents new to the home or returning to the home after receiving hospital care. 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.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. Given the discrepancies identified between residents' personal medication records and medicine administration records a robust auditing system encompassing all aspects of medicines management is required to ensure that safe systems are in place. The date of opening was not consistently recorded on all medicines meaning they could not be easily audited. An area for improvement was identified.

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.

Training in medicines management and competency assessments had been completed by staff within the last year, however given the findings of this inspection it was deemed that learning from training had not been fully implemented and competency assessments had not been effective in identifying deficits in practice. A comprehensive review of training and competency of all staff that have responsibility for managing medicines must be undertaken. An area for improvement was identified.

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.

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan and include personal medication records, medication administration records, medicine audits and staff training.

Whilst we identified areas for improvement, we can conclude that overall, with the exception of a small number of medicines, the residents were being administered their medicines as prescribed.

Following the inspection the findings were discussed with the Senior Pharmacist Inspector. RQIA decided that a period of time would be given to implement the necessary improvements. A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained. Failure to implement and sustain the improvements may lead to enforcement.

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 Homes Regulations (Northern Ireland) 2005 and the Residential Care Homes' Minimum Standards (August 2011).

	Regulations	Standards
Total number of Areas for Improvement	6*	4*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Chris Coulter, 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 29 **Stated:** Second time **To be completed by:** With immediate effect (11 May 2021)	The registered person shall ensure that reports produced following monthly monitoring visits are maintained within the home and accessible to residents, their representatives, staff and trust representatives. A copy of the report must also be forwarded to RQIA by the fourth day of each month until further notice.
	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 27 (2) (b) (d) **Stated:** First time **To be completed by:** 11 August 2021	The registered person shall ensure that the environmental issues identified during this inspection are addressed and that the home is decorated to an acceptable standard. With specific reference to: • door frames • skirting boards • paint work to walls.
	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 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered person shall ensure that personal medication records are fully and accurately completed and are reflective of the resident's currently prescribed medicines. Ref: 5.2.1

To be completed by: With immediate effect	**Response by registered person detailing the actions taken:** The prescribing pharmacist prepared and issued the MAR charts for each individuals prescribed medication. This included the name of the medication, dosage, and time of administration Each resident has a medication profile, medication assessment, patient information leaflets for each medication prescribed and a monthly MAR Chart When the inspection took place, the service referred to KARDEX in the service users Medication Profile for list of current medication. The KARDEX was an additional form that the service has created some time back. It is a handwritten document that could be open to errors in recording, as the MAR chart provides the most accurate and up to date information provided by the prescribing doctor to the pharmacist. Service users Medication Profiles have been updated to link to MAR Chart not Kardex and the Kardex is now withdrawn. An instruction has been given to staff both verbally and in writing for a copy of the current MAR Chart and Medication Profile to accompany any hospital admissions as the most accurate and up to date information
Area for improvement 4 **Ref:** Regulation 13(4) **Stated:** First time	The registered person shall ensure that complete and contemporaneous records of the administration of medicines are completed. Ref: 5.2.3
To be completed by: With immediate effect	**Response by registered person detailing the actions taken:** The prescribing pharmacist prepared and issued the MAR charts for each individuals prescribed medication. This included the name of the medication, dosage, and time of administration Each resident has a medication profile, medication assessment, patient information leaflets for each medication prescribed and a monthly MAR Chart When the inspection took place, the service referred to KARDEX in the service users Medication Profile for list of current medication. The KARDEX was an additional form that the service has created some time back. It is a handwritten document that could be open to errors in recording, as the MAR chart provides the most accurate and up to date information provided by the prescribing doctor to the pharmacist. Service users Medication Profiles have been updated to link to MAR Chart not Kardex and the Kardex is now withdrawn. An instruction has been given to staff both verbally and in writing for a copy of the current MAR Chart and Medication Profile to accompany any hospital admissions as the most accurate and up to date information

Area for improvement 5 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** With immediate effect	The registered person should ensure a robust system of audit which encompasses all aspects of medicines management is implemented to ensure safe systems are in place. Ref: 5.2.5
	Response by registered person detailing the actions taken: The registered manager in association with the Area Manager will review the suite of policies, procedures and associated tools currently in place within Potens and ensure that all relevant ones are in place at service. A service specific procedure will be created, outlining this and will be stored at the front of the medication file. Weekly & Monthly Medication Audits are comprehensive and will be reviewed as part of Area Manager Audit each month, in line with the service specific procedure in operation.
Area for improvement 6 **Ref:** Regulation 20 (c) **Stated:** First time **To be completed by:** 12 October 2021	The registered person should ensure a comprehensive review of training and competency of all staff that have responsibility for managing medicines is undertaken. Ref: 5.2.6
	Response by registered person detailing the actions taken: Review of staff training in relation to Medication has been undertaken. Staff have all completed mandatory medication training and this is renewed annually. Competency Observations will be carried out with all staff who administer medication. Medication Theory Packs have also been issued to all staff who administer medication to review their level of understanding and competence in relation to safe administration of medication. This will also be renewed 6 monthly. Both competency observations and Theory packs will be completed by 30/09/21 and reviewed as part of Area Managers Monthly Audit and reported in Managers Monthly Report. In addition, all staff are being booked on to Face 2 Face Medication training and this training will be completed by end of October 2021
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 6.6 **Stated:** Third time final time	The registered person shall ensure that when the needs of a resident have changed, their care records are amended to accurately reflect these changes and any recommendations made by health care professionals.

To be completed by: 11 July 2021	**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: 5.1
Area for improvement 2 **Ref:** Standard 21 **Stated:** Third and final time **To be completed by:** 11 July 2021	The registered person shall ensure that policies and procedures are centrally indexed, are subject to a systematic three yearly review and are available for staff and residents where applicable.
	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: 5.1
Area for improvement 3 **Ref:** Standard 20 **Stated:** Second time **To be completed by:** 11 July 2021	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. With specific reference to: • Care records • Hand 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: 5.1
Area for improvement 4 **Ref:** Standard 23.1 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that initial induction and orientation records are maintained in the employees file for inspection.
	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: 5.1

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