Inspection Report

Name of Service: Drumary House

Provider: Potensial Limited

Date of Inspection: 15 October 2024

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 Limited
Responsible Individual/Responsible Person:	Miss Nicki Stadames
Registered Manager:	Mr Chris Carr, not registered
Service Profile: Drumary House is a residential care home registered to provide health and social care for up to 17 residents with a learning disability. Accommodation is provided in single bedrooms and all residents have access to communal spaces and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 15 October 2024, from 10.45am to 1.30pm. This was completed by a pharmacist inspector and focused on medicines management within the home.

Review of medicines management found that medicines were stored securely, medicine records and medicine related care records were generally well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. One new area for improvement was identified in relation to ensuring the date of opening is recorded on eye preparations to facilitate disposal on expiry, as detailed in the quality improvement plan.

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

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.

The inspection was completed by reviewing a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines, to evidence how the home is performing in relation to the regulations and standards. Discussions were held with staff and management about how they plan, deliver and monitor the management of medicines.

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

Throughout the inspection the RQIA inspector will seek to speak with residents, their relatives or visitors and staff to obtain their opinions on the quality of the care and support, their experiences of living, visiting or working in this home.

The inspector spoke with staff and management to seek their views of working in the home.

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 said that the team communicated well and the management team were 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.

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.

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 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.

One obsolete personal medication record had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly. This was highlighted to the manager for immediate action and ongoing monitoring.

Copies of residents' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription. This is good practice.

All residents should have care records 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.

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 records 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 records were in place. Records of administration were maintained. One personal medication record needed updated to include the recommended consistency level and assurances were provided that this would be actioned immediately.

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.

Records reviewed 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 medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. The current temperature of the medicine refrigerator was monitored each day; this does not provide evidence that the temperature is

maintained within the required range at all times. The manager provided an assurance that the maximum, minimum and current temperature would be recorded and monitored daily.

A number of eye preparations had no recorded date of opening and were removed for disposal, since these medicines have a limited shelf-life once opened. The management of in-use eye preparations should be reviewed to ensure that the date of opening is recorded to facilitate disposal on expiry. An area for improvement was identified.

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. Most of the records were found to have been accurately completed. One hand written medicine administration record had not been signed and verified as accurate by two members of staff. This was highlighted for close monitoring. Records were filed once completed and were readily retrievable for audit/review.

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 the majority of medicines so that they could be easily audited, see Section 3.3.2.

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 the time of admission or for residents returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

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 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 the learning shared with staff in order to prevent a recurrence.

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

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.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal.

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

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	3*

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

The new area for improvement and details of the Quality Improvement Plan were discussed with Mr Chris Carr, Manager, as part of the inspection process. The timescale for completion commences from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022) (Version 1:2)	
Area for improvement 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** Immediate and ongoing (15 October 2024)	The registered person shall ensure that the date of opening is recorded on all medicines to facilitate disposal on expiry. This is stated in relation to eye preparations. Ref: 3.3.2
	Response by registered person detailing the actions taken: A full audit of the medication cabinet was carried out immediately after the inspection. All eye preparations that were present were returned to the pharmacy and new stock put in place with the opening date recorded. A communication (memo) was created and circulated to all staff to remind them of the importance of recording the 'opened on' date on all eye preparations, boxed medication, creams and bottles. As part of the recorded process of administration, we have added a 'check date of opening' prompt. This will be checked as part of the weekly medication audits and reviewed as part of the overall monthly medication auditing, to ensure compliance.
Area for improvement 2 **Ref:** Standard 27.1 **Stated:** First time **To be completed by:** 31 July 2024	The registered person shall ensure that the identified bedroom is repainted.
	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.
Area for improvement 3 **Ref:** Standard 35.1 **Stated:** First time **To be completed by:** 16 September 2024	The registered person shall ensure that the identified seating is repaired/addressed so that it can be effectively cleaned.
	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.

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

The Regulation and Quality Improvement Authority

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