The Regulation and Quality Improvement Authority

Inspection Report

27 April 2021

Granard

Type of service: Residential Care Home
Address: 12 Hospital Road, Omagh BT79 0AN
Telephone number: 028 8224 1143

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: East Eden Ltd **Responsible Individual:** Dr Una McDonald	**Registered Manager:** Mrs Carmel Rodgers **Date registered:** 11 March 2013
Person in charge at the time of inspection: Mrs Carmel Rodgers	**Number of registered places:** 26 This number includes: • category RC-I for one identified individual • a maximum of one resident to be accommodated in category of care RC-PH
Categories of care: Residential Care (RC): MP(E) - mental disorder excluding learning disability or dementia – over 65 years MP – mental disorder excluding learning disability or dementia I – old age not falling within any other category LD – learning disability LD (E) – learning disability – over 65 years DE – dementia PH – physical disability other than sensory impairment	**Number of residents accommodated in the residential care home on the day of this inspection:** 24
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for 26 residents.	

2.0 Inspection summary

An unannounced inspection took place on 27 April 2021 between 10.15am and 3.20pm. The inspection was completed by a pharmacist inspector.

This inspection focused on medicines management within the home and assessed progress with any areas for improvement in relation to medicines management identified since the last care and medicines management inspections.

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.

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

4.0 What people told us about the service

The inspector met with 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.

In order to reduce the footfall throughout the home, the inspector met with a small number of residents briefly. The residents did not raise any concerns regarding the care provided.

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 returned from residents/ their representatives. No staff responses were received.

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 care inspection on 4 February 2021		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 31 **Stated:** First time	The registered person should ensure that personal medication records are up to date and verified and signed by two trained members of staff.	**Not met**
	Action taken as confirmed during the inspection: The majority of personal medication records had been verified and signed by two trained members of staff. However, several personal medication records were not up to date. **This area for improvement was stated for a second time.**	
Area for Improvement 2 **Ref:** Standard 31 **Stated:** First time	The registered person shall ensure that the medication administration records are accurately maintained and that hand-written updates are verified and signed by two members of staff.	**Not met**
	Action taken as confirmed during the inspection: Several medication administration records were not accurately maintained. Hand-written medication administration records were not verified and signed by two members of staff. **This area for improvement was stated for a second time.**	

Area for Improvement 3 **Ref:** Standard 6 **Stated:** First time	The registered person shall ensure the identified residents care plan is reviewed and updated to reflect how the identified condition is managed. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.**	**Carried forward for review at 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 residents' needs will 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 16 out of the 17 residents selected for review. These records are 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. We found that some of the personal medication records were not up to date, medication changes had not been accurately recorded and that not all had been verified and signed by two members of staff to ensure accuracy. The area for improvement identified at the last inspection was stated for a second time.

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, 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. Directions for use were clearly recorded on the personal medication records and records of administration were maintained Staff on duty knew how to recognise signs, symptoms and triggers which may cause a change in each resident’s behaviour and were aware that this change may be associated with pain. However, care plans did not provide sufficient detail to direct the use of these medicines. The reason for and outcome of each administration were not recorded. 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 were in place. It was agreed that the care plans would be updated to include details of any prescribed medicines.

Staff supervised the administration of insulin for a small number of residents. In-use insulin pens were stored at room temperature and individually labelled to denote ownership. The date of opening was recorded on each pen to facilitate audit and disposal at expiry. Dosage directions were recorded on the personal medication records. For one resident staff were not recording the actual dose administered. For a second resident the care plan was not up to date and staff had recorded the administration of the incorrect dose. The manager provided assurances that the correct doses were being administered as they are checked at each administration by a member of staff and the resident. The management of insulin should be reviewed to ensure that care plans are up to date and the actual dose administered is recorded. An area for improvement was identified.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time?

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.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their viability. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures every day and to reset the thermometer. It was noted that only the current refrigerator temperature was recorded each day and it was outside the accepted range. An area for improvement was identified.

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. Several of the records had not been accurately completed. The following shortfalls were observed:

- missed signatures; the audits indicated that the medicines had been administered however, staff had not completed the records accurately
- the month and year of administration were not recorded on hand-written MARs, therefore when these records are archived the date of administration will not be able to be determined
- two staff had not verified and signed hand-written MARs in order to ensure accuracy of transcribing
- completed MARs had not been archived appropriately to facilitate retrieval for audit and review.

These findings were discussed in detail with the manager for immediate corrective action. An area for improvement was identified for a second time.

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 in Schedule 2 were recorded in a controlled drug record book. Staff were reminded that the name and strength of the controlled drug must be accurately recorded on each page.

Management and staff audited medicine administration on a regular basis within the home. A review of these audits indicated that they did not cover record keeping, care planning and the storage of medicines. The audits were not effective in identifying shortfalls in the management and administration of medicines. The auditing system must be reviewed to ensure that it covers all aspects of the management and administration of medicines. It was suggested that the quality improvement plan should be reviewed as part of the audit and that medicines management should be reviewed during the monthly monitoring visits completed in accordance with Regulation 29. An area for improvement was identified.

The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

The audits completed during this inspection showed that residents had been given their medicines as prescribed. However, a number of audits could not be completed due to the poor standard of record keeping.

The medicine cups used to administer medicines to residents were labelled as single use. Therefore, they should be discarded after each use. The manager advised that the cups are washed after use and then reused. This matter was discussed with the manager who gave an assurance that this practice would stop.

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.

The management of two admissions to the home was reviewed. Robust arrangements were in place to ensure that staff were provided with a list of prescribed medicines and this was shared with the GP and community pharmacist. However, the personal medication record could not be located for one resident. For both residents the medication administration records were not accurately maintained. In addition, records of the quantity of each medicine received into the home had not been maintained. This meant that there was no clear audit trail to provide evidence that the medicines had been administered as prescribed. An area for improvement was identified.

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.

There had been no medication related incidents reported to RQIA. The manager was advised that the current auditing system may be ineffective in identifying incidents.

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.

The manager advised that staff in the home had received a structured induction which included medicines management when this forms part of their role and that competencies are reassessed annually. The findings of this inspection indicate that staff require further training on medicines management. The training should include: record keeping, care planning, the management of medicines on admission, insulin, distressed reactions and the cold storage of medicines. 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 regarding the management of medicines.

The outcome of this inspection concluded that robust arrangements were not in place for all aspects of medicines management. Two areas for improvement identified at the last medicines management inspection had not been addressed and have been stated for a second time. In addition areas for improvement in relation to the management of medicines on admission, insulin, distressed reactions, cold storage, auditing and training were identified.

Following the inspection the findings were discussed with the senior pharmacist inspector and with two members of East Eden Ltd management team. On 28 April 2021 the management team submitted an action plan to address the identified shortfalls. 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 were 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	4	5*

* The total number of areas for improvement includes one that has been carried forward for review at the next inspection and two which have been identified for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Carmel Rodgers, Registered Manager, and other members of the management team, 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 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that the maximum and minimum refrigerator temperatures are accurately monitored each day. Corrective action must be taken if temperatures outside the accepted range are observed. Ref: 5.2.2
	Response by registered person detailing the actions taken: A change of recording sheet allows for the temperature to be recorded twice daily and reflects current, minimum amd maximum range. When the temperature runs over the maximum range the thermometer is reset and this appears to resolve to within acceptable range.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall implement a robust audit which covers all aspects of the management of medicines. Action plans to address any shortfalls should be implemented and addressed. Ref 5.2.3 & 5.2.5
	Response by registered person detailing the actions taken: The medication auditing system has been reviewed and strengthed to include all aspects of medication management. An action plan was developed on the 28 April 2021, it remains in place and reviewed weekly by senior management. The action plan identifies progress. Further audits have been completed by the associated pharmacy.
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall review the management of medicines on admission to ensure that personal medication records, medication administration records and records of medicine received into the home are accurately maintained. Ref 5.2.4
	Response by registered person detailing the actions taken: On admission to the Home 2 staff check in medication and transfer to personal medication records, and maintain administration records. This practice is included in audits.

Area for improvement 4 **Ref:** Regulation 20 (1) (c) **Stated:** First time **To be completed by:** 28 May 2021	The registered person shall ensure that all staff who manage medicines receive additional training and competency is assessed. Ref 5.2.6 **Response by registered person detailing the actions taken**: Medication training with the Home Manager and staff has been completed. Competency assessments have also been completed.
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 31 **Stated:** Second time **To be completed by:** From the date of the inspection	The registered person should ensure that personal medication records are up to date and verified and signed by two trained members of staff. Ref 5.1& 5.2.1 **Response by registered person detailing the actions taken**: Personal medication records are up to date and signed by two people. Medication records are audited weekly to ensure this practice continues.
Area for improvement 2 **Ref:** Standard 31 **Stated:** Second time **To be completed by:** From the date of the inspection	The registered person shall ensure that the medication administration records are accurately maintained and that hand-written updates are verified and signed by two members of staff. Ref 5.1 & 5.2.3 **Response by registered person detailing the actions taken**: Audits identify that medication administration records are accurately maintain and two staff members have verified and signed.
Area for Improvement 3 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 3 October 2020	The registered person shall ensure the identified residents care plan is reviewed and updated to reflect how the identified condition is managed. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.** Ref: 5.1

Area for improvement 4 **Ref:** Standard 6 **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall review the management of distressed reactions to ensure that: • care plans contain sufficient detail to direct the required care • the reason for and outcome of each administration are recorded. Ref 5.2.1
	Response by registered person detailing the actions taken: Staff have reviewed and updated care plans relating to distressed behaviours to ensure that detail is sufficient to direct the the required care, the reason for and the outcome of medication provided at time of distress.
Area for improvement 5 **Ref:** Standard 30 **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall review the management of insulin to ensure that: • cares plans are up to date • the actual dose administered is recorded. Ref 5.2.1
	Response by registered person detailing the actions taken: Care plans have been reviewed and updated in relation to insulin management with input from community specialist.Training has been provided relating to safe insulin management.

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