The Regulation and Quality Improvement Authority

Inspection Report

27 July 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 Limited **Responsible Individual:** Dr Una McDonald	**Registered Manager:** Mrs Carmel Rodgers **Date registered:** 11 March 2014
Person in charge at the time of inspection: Mrs Carmel Rodgers	**Number of registered places:** 26 This number includes: • one identified individual in category RC-I • a maximum of one resident in category of care RC-PH
Categories of care: Residential Care (RC): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years 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:** 25
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 26 residents.	

2.0 Inspection summary

An unannounced inspection took place on 27 July 2021from 10.45 and 14.15. The inspection was carried out by a pharmacist inspector.

The findings of the last medicines management inspection (27 April 2021) indicated that robust arrangements were not in place for all aspects of medicines management.

Areas for improvement were identified in relation to the standard of maintenance of the personal medication records and medication administration records, the management of medicines on admission, insulin, distressed reactions, cold storage, auditing and training. These findings were discussed with two members of East Eden Ltd management team following the inspection and with the senior pharmacist inspector. On 28 April 2021 the management team submitted an action plan to RQIA outlining how the shortfalls would be addressed. RQIA decided that a period of time would be given to implement the necessary improvements and that this follow up inspection would be undertaken to determine if the necessary improvements had been implemented and sustained.

Significant improvements in the management of medicines were observed at this inspection. There were robust arrangements for auditing medicines and medicine records were well maintained. Arrangements were in place to ensure that staff were trained and competent in medicines management. The manager and staff are commended for their efforts. The manager was reminded that the improvements must be sustained.

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, the deputy manager and one care assistant. 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 advised that they had worked hard to improve the management of medicines and that the changes implemented had been effective and were sustainable.

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, one questionnaire had been returned by a relative. Their response indicated that they were "very satisfied" with all aspects of the care provided.

5.0 The inspection

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

The last medicines management inspection was undertaken on 27 April 2021. The areas for improvement with regards to medicines management identified at that inspection were subsumed into the quality improvement plan resulting from the care and finance inspection which was carried out on 1 & 7 July 2021.

Areas for improvement from the last care and finance inspection (1 & 7 July 2021)		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Satisfactory readings were observed for the refrigerator temperature. **See Section 5.2.6**	
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time	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.	**Met**

	Action taken as confirmed during the inspection: A robust audit tool had been developed and implemented. Action plans had been addressed. **See Section 5.2.8**	
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Satisfactory systems were in place for the management of medicines on admission. **See Section 5.2.3**	
Area for improvement 4 **Ref:** Regulation 20 (1) (c) **Stated:** First time	The registered person shall ensure that all staff who manage medicines receive additional training and competency is assessed.	**Met**
	Action taken as confirmed during the inspection: Records of the staff training and competency assessments which had been completed since the last inspection were available for inspection. **See Section 5.2.7**	
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for improvement 1 **Ref:** Standard 31	The registered person should ensure that personal medication records are up to date and verified and signed by two trained members of staff.	**Met**

Stated: Second time	**Action taken as confirmed during the inspection**: Personal medication records were up to date. They were verified and signed by two trained members of staff to ensure accuracy. **See Section 5.2.1**	
Area for improvement 2 **Ref:** Standard 31 **Stated:** Second 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.	**Met**
	Action taken as confirmed during the inspection: Medication administration records were accurately maintained. Hand-written updates were verified and signed by two members of staff to ensure accuracy. **See Section 5.2.2**	
Area for improvement 3 **Ref:** Standard 6 **Stated:** First time	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	**Met**
	Action taken as confirmed during the inspection: Satisfactory systems were in place for the management of distressed reactions. **See Section 5.2.4**	
Area for improvement 4 **Ref:** Standard 30 **Stated:** First time	The registered person shall review the management of insulin to ensure that: • cares plans are up to date • the actual dose administered is recorded	**Met**
	Action taken as confirmed during the inspection:	

	Satisfactory systems were in place for the management of insulin. **See Section 5.2.5**	
Area for improvement 5 **Ref:** Standard 27 **Stated:** First time	The registered person shall ensure that the identified shower room is decluttered thus ensuring easy access for resident use. **Action required to ensure compliance with this standard was not reviewed at this inspection and is carried forward for review at the next care inspection.**	**Carried forward for review at the next inspection**
Area for improvement 6 **Ref:** Standard 17.10 **Stated:** First time	The registered person shall ensure that records are kept of all complaints and these include details of all communications with complainants, the result of any investigations and the action taken. **Action required to ensure compliance with this standard was not reviewed at this inspection and is carried forward for review at the next care inspection.**	**Carried forward for review at the next inspection**

5.2 Inspection findings

5.2.1 Personal medication records

Personal medication records were in place for all 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, for example at medication reviews and hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. Medication changes had been accurately recorded. The records had been verified and signed by two members of staff at the time of writing and at each update in order to ensure accuracy of transcribing.

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.

5.2.2 Medication administration records

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. The sample of these records reviewed had been accurately completed.

Hand-written MARs had been verified and signed by two staff in order to ensure accuracy of transcription. The month and year had been accurately recorded on hand-written MARs and completed MARs had been archived appropriately to facilitate retrieval for audit and review.

5.2.3 The management of medicines on admission to the home

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 admissions to the home was reviewed. Robust arrangements were in place to ensure that staff were provided with an accurate list of prescribed medicines and this was shared with the GP and community pharmacist. Personal medication records and hand-written medication records were verified and signed by two staff to ensure accuracy. Records of the quantity of each medicine received into the home had been accurately maintained. The audits completed at the inspection indicated that records had been accurately maintained and medicines had been administered as prescribed.

5.2.4 The management of medicines prescribed on a “when required” basis for the management of distressed reactions.

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. Care plans provided sufficient detail to direct the use of these medicines. The reason for and outcome of each administration were recorded on the majority of occasions.

5.2.5 The management of insulin

Staff supervised the administration of insulin for a small number of residents.

Care plans for the management of insulin were up to date. Dosage directions were clearly recorded on the personal medication records. Blood glucose levels and the actual dose of insulin administered were recorded.

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.

5.2.6 The management of medicines which require cold storage

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.

A new template was in place to facilitate the recording of the current, maximum and minimum refrigerator temperatures each day. The daily records were reviewed. The current, maximum and minimum temperatures were recorded each day and were within the accepted range. The thermometer was reset each day.

5.2.7 Staff training and competency assessment

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.

Update training on the management of medicines which covered record keeping, care planning, the management of medicines on admission, insulin, distressed reactions and the cold storage of medicines was provided by the Trust pharmacist in May 2021 and June 2021. Training on the management of diabetes was also provided.

Competency assessments were completed following this training.

The findings of this inspection indicate that the training has been effective in driving the necessary improvements.

5.2.8 Governance and audit

Following the last inspection an action plan to address the identified shortfalls in medicines management was developed and implemented. The action plan was reviewed monthly as part of the Regulation 29 monitoring visits.

A revised medicines management audit tool was developed. The manager and deputy manager initially completed this audit weekly. This frequency was reduced to fortnightly as improvements were observed to have been sustained. Any necessary actions were discussed with staff for immediate implementation.

A daily handover sheet was completed by all staff to confirm that they have checked that records of prescribing and administration have been accurately completed.

The majority of medicines were contained within the blister pack system. At the last medicines management inspection a number of audits could not be completed due to the poor standard of record keeping. Improvements in record keeping meant that all audits could be completed and showed that medicines were administered as prescribed.

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 all areas for improvement identified at the last medicines management inspection had been addressed. No new areas for improvement were identified. RQIA can be assured that the home was well led and delivering safe, effective and compassionate care with regards to medicines management. The manager was reminded that the improvements must be sustained.

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

7.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	2*

* The total number of areas for improvement includes two under the Standards which are carried forward for review at the next inspection. No new areas for improvement with regards to medicines management were identified at this inspection.

Quality Improvement Plan

Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 27 **Stated:** First time **To be completed by:** 2 July 2021	The registered person shall ensure that the identified shower room is decluttered thus ensuring easy access for resident use.
	Action required to ensure compliance with this standard was not reviewed at this inspection and is carried forward for review at the next care inspection. Ref 5.1
Area for improvement 2 **Ref:** Standard 17.10 **Stated:** First time **To be completed by:** 2 July 2021	The registered person shall ensure that records are kept of all complaints and these include details of all communications with complainants, the result of any investigations and the action taken.
	Action required to ensure compliance with this standard was not reviewed at this inspection and is carried forward for review at the next care inspection. Ref 5.1

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