Inspection Report

24 August 2023

Slieveleague

Type of service: Residential Care Home
Address: 34 Cullion Road, Edenmore, Tempo, BT94 3AR
Telephone number: 028 8954 1327

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: Slieveleague **Responsible Individual:** Mr John James Wesley Kerr	**Registered Manager:** Mrs Patricia Grimes **Date registered:** 7 December 2015
Person in charge at the time of inspection: Mrs Patricia Grimes	**Number of registered places:** 8 The home is approved to provide care on a day basis only to two persons.
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 PH(E) - physical disability other than sensory impairment – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 7
Brief description of the accommodation/how the service operates: Slieveleague is a residential care home registered to provide health and social care for up to eight residents. The home is a two storey building with residents' bedrooms located over two floors. Residents have access to a lounge, dining room and garden.	

2.0 Inspection summary

An unannounced inspection took place on 24 August 2023, from 10.30am to 1.20pm. This was completed by a pharmacist inspector. The inspection focused on medicines management within the home. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

One area for improvement identified at the last inspection had been addressed and the other areas for improvement identified at the last care inspection have been carried forward and will be followed up at the next care inspection

Review of medicines management found that generally safe systems were in place for the management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines. One new area for improvement was identified regarding ensuring that personal medication records are signed and verified as accurate by two trained members of staff when written and when updates are made.

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

Based on the inspection findings and discussions held, 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 management team with respect to medicines management.

RQIA would like to thank the residents and staff for their assistance throughout the 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. The inspection was completed by examining 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. The inspector spoke with 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 care staff and the manager. Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs.

Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well.

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. Five questionnaires were returned and all stated that they were very satisfied with all aspects of care provided in Slieveleague.

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 13 April 2023		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person shall ensure that any deviation to recommendations made by SALT regarding a resident's level of supervision are firstly discussed and agreed with SALT and relevant care records are updated to reflect the agreed changes.	**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.	
Action required to ensure compliance with Residential Care Homes Minimum Standards (2021)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 32 **Stated:** Second time	The registered person shall ensure that the maximum and minimum temperature of the medicines refrigerator is monitored and recorded. The temperature should be within the range of 2ºC and 8ºC.	**Met**
	Action taken as confirmed during the inspection: Records were in place for monitoring and recording the maximum, minimum and current temperatures daily when the refrigerator is in use. There were no medicines requiring cold storage at the time of the inspection but records were available for review for days in the month of July 2023 when the refrigerator was in use.	

Area for improvement 2 **Ref:** Standard 4 **Stated:** Second time	The registered person shall ensure that each resident has an individual written agreement setting out the terms of residency regarding the services and facilities to be provided. The resident or their representative and the registered person sign the agreement prior to, or within five working days of admission. Where the resident or their representative is unable to sign or chooses not to sign, this is recorded. **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 8.7 **Stated:** Second time	The registered person shall ensure that the residents' inventory of personal possessions is obtained on admission and kept up to date with additional items brought into the residents' rooms or when items are disposed of. A reconciliation of the records should be undertaken at least quarterly. Two signatures should be recorded against the reconciliation. **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 3.4 **Stated:** First time	The registered person shall ensure that a pre-admission assessment form is completed prior to a resident's admission and is retained within the resident's file. **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 20 **Stated:** First time	The registered person shall ensure that effective quality assurance audits are maintained to assess the delivery of care in the home. With specific reference to: • care records	**Carried forward to the next 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.	

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 may 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 mostly accurate and up to date. One discrepancy was highlighted to the manager for attention. However, personal medication records had not been signed and dated when written or updated. A second member of staff had not checked and signed the personal medication records when they were written and updated to state that they were accurate. 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.

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 distressed reactions was reviewed for two residents. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a resident's behaviour and was aware that this change may be associated with pain. Records included the reason for and outcome of each administration.

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. One resident required a care plan to direct staff and the manager gave an assurance that this would be actioned immediately following the inspection.

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 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 current, maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. The current, maximum and minimum temperature of the medicine refrigerator was recorded when the medicines refrigerator was in use and all records reviewed were within the required range.

Satisfactory arrangements were in place for the safe disposal of medicines.

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.

A sample of the medicines administration records was reviewed. All of the records reviewed were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for audit.

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 should be recorded in the controlled drug record book. The date of return to pharmacy/transfer for a small number of controlled drugs had not been recorded and balances had not been brought to zero; this was discussed for corrective action and close monitoring.

Staff audited medicine administration on a regular basis within the home. The date of opening was recorded on the majority of 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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new residents or residents returning from hospital. Written confirmation of the resident's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

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. A robust audit system will help staff to identify medicine related incidents.

There has been no medicine related incidents reported to RQIA since the last medicines inspection. Management and staff were familiar with the type of incidents that should be reported. The manager was directed to the guidance issued by RQIA on the notification of medication related incidents and agreed to share this with staff.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. This were highlighted to the manager for close monitoring.

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 they are supported.

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.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with Residential Care Homes Minimum Standards 2022.

	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 Mrs Patricia Grimes, Registered 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 Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** From the date of inspection (13 April 2023)	The registered person shall ensure that any deviation to recommendations made by SALT regarding a resident's level of supervision are firstly discussed and agreed with SALT and relevant care records are updated to reflect the agreed changes. **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
Action required to ensure compliance with the Residential Care Homes Minimum Standards 2022	
Area for improvement 1 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 13 May 2023	The registered person shall ensure that each resident has an individual written agreement setting out the terms of residency regarding the services and facilities to be provided. The resident or their representative and the registered person sign the agreement prior to, or within five working days of admission. Where the resident or their representative is unable to sign or chooses not to sign, this is recorded. **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 8.7 **Stated:** Second time **To be completed by:** 13 May 2023	The registered person shall ensure that the residents' inventory of personal possessions is obtained on admission and kept up to date with additional items brought into the residents' rooms or when items are disposed of. A reconciliation of the records should be undertaken at least quarterly. Two signatures should be recorded against the reconciliation. **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 3.4 **Stated:** First time **To be completed by:** From the date of inspection (13 April 2023)	The registered person shall ensure that a pre-admission assessment form is completed prior to a resident's admission and is retained within the resident's file.
	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 20 **Stated:** First time **To be completed by:** 13 May 2023	The registered person shall ensure that effective quality assurance audits are maintained to assess the delivery of care in the home. With specific reference to: • care records
	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 5 **Ref:** Standard 31 **Stated:** First time **To be completed by:** Immediate and ongoing (24 August 2023)	The registered person shall ensure that personal medication records are signed and verified as accurate by two trained members of staff when written and when updated. Ref 5.2.1
	Response by registered person detailing the actions taken: Personal medication records have all been verified and signed by rwo trained staff.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

RQIA, 1st Floor
James House
Gasworks
2 – 4 Cromac Avenue
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care