The Regulation and Quality Improvement Authority

Inspection Report

15 November 2021

Seymour Gardens

Type of service: Residential Care Home
Address: Nelson Drive, Waterside, Londonderry, BT47 6ND
Telephone number: 028 7134 4470

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: Western Health and Social Care Trust **Responsible Individual:** Mr Neil Guckian (registration pending)	**Registered Manager:** Mrs Elish Morris **Date registered:** Acting Manager, not registered
Person in charge at the time of inspection: Mrs Elish Morris	**Number of registered places:** 25
Categories of care: Residential Care (RC): DE – dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 16
Brief description of the accommodation/how the service operates: This is a residential care home which provides care for up to 25 residents living with dementia.	

2.0 Inspection summary

An unannounced inspection took place on 15 November 2021 from 11.00am to 3.10pm. It was undertaken by a pharmacist inspector.

The inspection focused on medicines management within the home and also assessed progress with any areas for improvement identified since the last care inspection.

Review of medicines management found that overall residents were being administered their medicines as prescribed. Arrangements were in place to ensure that staff received training and were deemed competent in medicines management. Most of the medicine records were well maintained and medicines were stored safely and securely. Systems were in place to audit medicines management on a regular basis.

Two new areas for improvement were identified in relation to medicine related care plans and management of medicine changes.

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 we reviewed information held by RQIA about this home. This included previous inspection findings, incidents and correspondence. To complete the inspection we reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. Staff and residents' views were also obtained.

4.0 What people told us about the service

The inspector met with a small number of residents. Residents were relaxed and content in the home. They were complimentary about the staff, how well they were looked after and said they were happy in the home. No concerns were raised.

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

Staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

There had been changes in management and the new manager had been recently appointed. Discussions with staff indicated there were good working relationships and team working in the home. They also said that they had the appropriate training to look after residents and meet their needs.

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, eight questionnaires had been received by RQIA. The responses were positive, indicating that the residents were very satisfied with the care provided.

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 22 June 2021		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 17.10 **Stated:** First time	The registered person shall ensure that in the recording of complaints, clear details of actions taken and confirmation if the complainant was satisfied or not with outcome are documented.	**Met**
	Action taken as confirmed during the inspection: A review of the complaints file indicated that no complaints had been received since the last inspection. A new complaints form had been developed and a sample of this form was provided. It included sections regarding the complaint details, actions taken, learning identified and if the complainant was satisfied or not with the outcome. There was evidence that staff reviewed this file each month.	
Area for improvement 2 **Ref:** Standard 27.1 **Stated:** First time	The registered person shall make good the wall paper in the corridor alcove.	**Met**
	Action taken as confirmed during the inspection: The wall paper had been replaced.	
Area for improvement 3 **Ref:** Standard 6.3 **Stated:** First time	The registered person shall ensure there is evidence to confirm that residents' representatives are consulted in the care planning process, where appropriate.	**Met**
	Action taken as confirmed during the inspection: A sample of care files was reviewed. There was evidence that the resident's representative had signed and dated the care plan/or a care plan summary sheet.	

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, at medication reviews or hospital appointments.

Most of the personal medication records reviewed at the inspection 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 check accuracy. However, amended entries were noted and discussed; a few required rewriting. A new format of personal medication record had commenced for one resident, and is scheduled to be in place for all residents by 22 November 2021 with assistance from a Trust pharmacist. It was agreed that the observations raised would be addressed within this transition process.

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 safe 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. 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; however, two care plans were not in place and one required more detail. Records of administration were clearly recorded and 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. There was reference to the resident's pain management in some care plans; however, more detail is necessary for residents who cannot verbally communicate pain. An area for improvement was identified.

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. A medicine refrigerator and controlled drugs cabinet were available for use as needed. One expired eyed preparation was removed for disposal. It was agreed that eye preparations would be closely monitored with the audit process.

Discontinued medicines were safely 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.

A sample of medicine administration records was reviewed. Most of the records were found to have been fully and accurately completed and were filed securely once completed. A recent audit had identified missing signatures in relation to topical medicines administered by care staff and was being addressed with staff.

However, it was noted that for one medicine the dose was prescribed as twice daily, but was administered once daily, and for another medicine there was information regarding a dose reduction, which had not occurred. The manager provided an update after the inspection and both issues were addressed. Medicines must be administered as prescribed with systems in place to follow up on changes. An area for improvement was identified.

There were arrangements in place to audit medicines management. In line with best practice, the date of opening was recorded on medicines so that they could be easily audited. The manager advised of the outcomes of the last audit and the areas identified for improvement. An action plan was also provided after the inspection. With the exception of the two medicines

detailed the audits completed at the inspection showed that medicines were administered as prescribed.

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 medicines for new residents or residents discharged back to the home from hospital was reviewed. Written confirmation of the resident's medicine regime was received at or prior to admission and shared with the community pharmacy. Details were updated on the personal medication records by two staff.

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.

The audit system in place helps 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 had been managed appropriately. Any learning was shared with staff in order to prevent a recurrence.

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 reference.

There were records in place to show that staff were trained and deemed competent in medicines management. Refresher training in medicines management was scheduled for staff. Policies and procedures were in place and under review as part of the new records being implemented.

6.0 Conclusion

The outcome of this inspection concluded that all areas for improvement identified at the last inspection had been addressed. Whilst two new areas for improvement were identified, overall there were systems in place to monitor medicines management and the residents were being administered their medicines as prescribed.

Based on the inspection findings and discussions held we 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.

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 Minimum Standards (August 2021 version 1.1).

	Regulations	Standards
Total number of Areas for Improvement	0	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Elish Morris, 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 Residential Care Homes Minimum Standards (August 2021 version 1.1)	
Area for improvement 1 **Ref:** Standard 6 **Stated:** First time	The registered person shall ensure that medicine related care plans include the necessary detail and are monitored on an ongoing basis. Ref: 5.2.1
To be completed by: 15 December 2021	**Response by registered person detailing the actions taken:** Care plans for distressed reactions and pain relief were updated. Distressed reactions/Pain Management plan now includes Medications prescribed to help manage distress/pain, when it is appropriate to administer these medications and review of effectiveness of these medications.
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time	The registered person shall ensure that systems are in place to follow up changes in medicine information and ensure administration is as prescribed. Ref: 5.2.1
To be completed by: 15 December 2021	**Response by registered person detailing the actions taken:** New format for personal administration records completed and checked by pharmacist. Staff and Manager audit format amended to improve systems and ensure medications are administered as prescribed.

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

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