Inspection Report
25 November 2020

William Street Care Home

Type of service: Residential Care Home
Address: 98 William Street, Londonderry, BT48 9AD
Tel No: 028 7126 4213
Inspector: Judith Taylor

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a residential care home which is registered to provide care for up to 27 residents.

2.0 Service details

Organisation/Registered Provider: Western HSC Trust **Responsible Individual:** Dr Ann Kilgallen	**Registered Manager and date registered:** Ms Moia Patricia Irvine 1 April 2005
Person in charge at the time of inspection: Ms Moia Patricia Irvine	**Number of registered places:** 27
Categories of care: Residential Care (RC): I – old age not falling within any other category	**Total number of residents in the residential care home on the day of this inspection:** 16

3.0 Inspection focus

This was unannounced inspection, undertaken by a pharmacist inspector on 25 November 2020 from 10.50 to 15.05.

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

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to residents
- 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

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration
- medicine receipt and disposal
- controlled drugs
- care plans related to medicines management
- governance and audit arrangements for medicines management
- staff training and competency records regarding medicines management

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	4*

*The total number of areas for improvement includes one that has been stated for a second time under the standards and one that has carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with, Ms Moia Irvine, Registered Manager, and one other senior member of staff on duty, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

5.0 What has this home done to meet any areas for improvement identified at the last medicines inspection (12 April 2017) and last care inspection (19 February 2020)?

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered provider must ensure that the finding in relation to the removal and destruction of original records is investigated.	**Met**
	Action taken as confirmed during the inspection: The manager completed the investigation and advised of the corrective action taken.	
Area for improvement 2 **Ref**: Regulation 13(4) **Stated:** First time	The registered provider must put robust arrangements in place to ensure that medicine administration records are fully and accurately maintained at all times.	**Met**
	Action taken as confirmed during the inspection: A review of medicine records indicated significant improvement had been made in the completion of these records.	
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered provider must develop a robust audit process for medicines management.	**Met**
	Action taken as confirmed during the inspection: There was evidence of improved auditing arrangements to assess and oversee medicines management. Action plans to address any issues were put in place. A few sections to develop were discussed and addressed under a new area for improvement. See Section 7.3.	

Area for improvement 4 **Ref:** Regulation 13(4) **Stated:** First time	The registered provider must review the management of recording errors and audit outcomes to ensure that management are informed and these are managed in line with legislation and professional standards.	**Met**
	Action taken as confirmed during the inspection: The auditing arrangements included the standard of record keeping with particular focus on personal medication records and medication administration records. Systems were in place to follow up any issues noted.	
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 30 **Stated:** First time	The registered provider should provide further training for staff in medicines management and their professional accountability.	**Met**
	Action taken as confirmed during the inspection: Training had been provided following the last medicines management inspection and supervision held with staff. Staff competency in medicines management was assessed annually.	
Area for improvement 2 **Ref**: Standard 31 **Stated:** First time	The registered provider should ensure that two designated staff are involved in the writing and updating of medicine records.	**Partially met**
	Action taken as confirmed during the inspection: A review of medicine records indicated that two staff were involved in the writing and updating of records on some, but not all occasions. This area for improvement has been stated for a second time.	
Area for improvement 3 **Ref**: Standard 31 **Stated:** First time	The registered provider should ensure that records pertaining to controlled drugs are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: An improvement in the completion of controlled drug records was evidenced.	

Area for improvement 4 **Ref**: Standard 33 **Stated:** First time	The registered provider should closely monitor the administration of inhaled medicines and antibiotics to ensure these are administered in accordance with the prescribers' instructions.	**Met**
	Action taken as confirmed during the inspection: There was evidence that these medicines were regularly reviewed within the monthly audit process and records indicated they had been administered as prescribed.	
Area for improvement 5 **Ref**: Standard 30 **Stated:** First time	The registered provider should review the management of distressed reactions as detailed in the report.	**Carried forward to next inspection**
	Action taken as confirmed during the inspection: At the time of this inspection, there were no residents prescribed medicines to manage distressed reactions. Therefore, this area for improvement has been carried forward to the next inspection.	

Areas for improvement from the last care inspection		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 21.5 **Stated:** First time	The registered person shall ensure that the home retains current Operational Guidelines for Adult Safeguarding. This improvement was made in regard to the Operational Guidelines for Adult Safeguarding which was dated 2014.	**Met**
	Action taken as confirmed during the inspection: The manager advised of the action taken and that the new guidelines are currently under review. She assured that they have up to date information via the regional adult safeguarding guidelines. Given this assurance the area for improvement was assessed as met.	

6.0 What people told us about this home?

We observed residents relaxing in lounges or in their bedrooms, listening to music or watching television. We met with three residents. They spoke positively about their care in the home, the food provided, and had no concerns regarding their medicines. Comments made included:

- "I'm happy enough here."
- "Staff couldn't be better."
- "I am as happy here as the day is long."
- "Food is just perfect, there's plenty of it."

Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well and were familiar with their likes and dislikes. In relation to medicines management, staff were knowledgeable about the residents' medicines and recent changes.

We met with the three staff and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed. Staff expressed satisfaction with how the home was managed and advised us they felt supported in their role. 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, no staff questionnaires had been received by RQIA.

Nine questionnaires were returned from residents during the inspection. All were marked as very satisfied with their care in the home. Comments made:

- "I'm very happy with the care."
- "The balance of care and friendliness is impeccable."
- "The quality of care is exemplary and the level of communication is very good in both directions."

7.0 Inspection Findings

7.1 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, medical consultant or pharmacist.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for residents. 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 and hospital appointments.

The personal medication records reviewed at the inspection were generally well maintained. On some occasions, two staff had not been involved in the writing and updating of these records. This is necessary to ensure accurate information. The area for improvement made at the last medicines management inspection has been 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 pain. The manager advised that that staff were familiar with how each resident would express pain and that all residents could request pain relief when needed. Pain management care plans were maintained.

7.2 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. In addition, a record of all incoming and outgoing medicines must be maintained.

The records inspected showed that medicines were available for administration when residents required them. We noted that the receipt records were incomplete as the date received and dose prescribed was not documented. In relation to the disposal of medicines, these medicines were returned to the community pharmacy for disposal and records maintained. However, the records were incomplete regarding the reason for disposal and the date of transfer of medicines to the community pharmacy. These are necessary to show when the disposal occurred and when staff are no longer responsible for the medicines. An area for improvement was identified. It was agreed that these records would be reviewed in more detail within the audit process.

Staff advised of the stock and ordering process and recent changes to the process due to the pandemic. They stated 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. Suitable arrangements were in place for the safe storage of controlled drugs.

In relation to the appropriate cold storage of medicines, the refrigerator temperatures need to be monitored, recorded and the thermometer should be reset every day. There were gaps in the

daily recording and the temperatures were outside the accepted range of 2^{o}C to 8^{o}C. It was not clear if the thermometer was reset every day. We also removed medicines which must not or do not require refrigeration. An area for improvement was identified.

7.3 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, and that there are systems in place to monitor the records and medicines, to ensure that residents are receiving the correct prescribed treatment. There was evidence that the administration of medicines records were accurately maintained.

We also reviewed the administration of controlled drugs and warfarin.

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 are recorded in a controlled drug record book and all entries should be signed by two staff. We reviewed this record book and it had been generally well maintained. Staff were reminded that the stock balance must be brought to zero, when a supply is returned to the community pharmacy or discharged with the resident. The manager advised that this would be addressed with staff.

We reviewed the management of warfarin. This is a high risk medicine which requires robust systems to ensure that any changes in the doses are safely managed and the correct dose is being administered. There were largely satisfactory systems in place to manage this medicine, including the safe practice of two staff involved at each administration; however, we identified a discrepancy in the stock balance of one supply of warfarin. This was brought to the staff and manager's attention for immediate review. Following the inspection, this was investigated by the manager and details shared with RQIA; a reasonable explanation was obtained and this did not affect the resident; no further concerns were noted.

The auditing systems in place to monitor medicines administration and overall medicines management were reviewed. These are systems which if applied assist the manager in determining if the medicine systems is working well and also helps identify if there are areas to improve on. In this home, the manager and staff completed medicines management audits daily and on a monthly basis; all residents' medicines were included in the audits. The date of opening was recorded on all medicines so that they could be audited and this is good practice. We acknowledged the filing systems and ease of reference of medicine documents. This facilitated their auditing system and the inspection. The progress made following the last medicines management inspection was also acknowledged.

7.4 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.

We discussed the admission process for residents new to the home or returning to the home after receiving hospital care. Staff advised that robust arrangements were in place to ensure that they were provided with a list of medicines from the resident's GP; or if being admitted from hospital, a copy of the hospital letter was shared with the resident's GP and the community pharmacist.

7.5 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 process is necessary to ensure that systems are working well and can highlight deficits in the system; and so identify any medicine related incidents.

There have no medicine related incidents reported to RQIA. Staff were aware of the types of incidents which were required to reported and investigated.

7.6 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 to do this. In addition, it is necessary to have up to date policies and procedures which staff have easy access to, for reference as needed.

There was evidence of staff training and competency assessment in medicines management. Policies and procedures were in place and readily available for staff reference.

8.0 Evaluation of Inspection

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

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

Areas of good practice and progress made with the QIP from the last medicines management and care inspections were acknowledged with the manager. One area for improvement with regards to the personal medication records has been stated for a second time and one area for improvement in relation to the management of distressed reactions has been carried forward for review at the next inspection. Two new areas for improvement in relation to the cold storage of medicines and records of receipt and disposal were identified.

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

9.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Moia Irvine, Registered Manager and one senior member of staff, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

9.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

9.2 Actions to be taken by the home

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 13 April 2017	The registered provider should review the management of distressed reactions as detailed in the report. **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: 5.0
Area for improvement 2 **Ref**: Standard 31 **Stated:** Second time **To be completed by:** Immediately and ongoing	The registered provider should ensure that two designated staff are involved in the writing and updating of medicine records. Ref: 5.0 & 7.1 **Response by registered person detailing the actions taken:** All staff responsible for administration of medicines will ensure 2 staff are involved in the writing and upating of medicine records. Registered Manager will audit to ensure compliance.
Area for improvement 3 **Ref**: Standard 31 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure review the arrangements for the cold storage of medicines to ensure that temperatures are maintained within the accepted range and the thermometer is reset every day. Ref: 7.2 **Response by registered person detailing the actions taken:** Staff have been monitoring the fridge temperatures and noted some discrepancies. A new medical fridge has been ordered and Manager will ensure that temperatures are recorded as per policy.
Area for improvement 4 **Ref**: Standard 31 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that the receipt and disposal of medicines records are fully and accurately maintained. Ref: 7.3 **Response by registered person detailing the actions taken:** All staff responsible for administration of medicines will ensure that records are fully and accurately maintained. Registered Manager will regularly audit to ensure this is being carried out.

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

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