Inspection Report
3 December 2020

Limetree House

Type of Home: Residential Care Home
Address: 133/133A Comber Road, Dundonald, BT16 2BT
Tel No: 028 9048 9380
Inspector: Helen Daly

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 35 residents who are living with dementia.

2.0 Service details

Organisation/Registered Provider: Limetree **Responsible Individual:** Mrs Gertrude Alexandra Priscilla Nixon	**Registered Manager and date registered:** Mr Graham Moore, registration pending
Person in charge at the time of inspection: Mrs Deborah Moore, Deputy Manager	**Number of registered places:** 35
Categories of care: Residential Care (RC): DE – dementia	**Total number of residents in the residential care home on the day of this inspection:** 29

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 3 December 2020 from 10.15 to 13.40.

This inspection focused on medicines management within the home.

The inspection 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 the home. This included the last inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- 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 records
- medicine receipt and disposal records
- controlled drug records
- care plans related to medicines management
- governance and audit
- staff training and competency records
- medicine storage temperatures

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	1*

* The total number of areas for improvement includes one which has been carried forward for review at the next inspection.

No new areas for improvement were identified at this 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 management inspection (12 January 2018) and the last care inspection (28 February 2020) ?

No areas for improvement were identified at the last care inspection.

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 30

Stated: Second time</td><td>The management of warfarin should be reviewed to ensure that staff are able to refer to the original dosage directions at each administration and where transcribing is necessary, a second member of trained staff checks and signs the record to ensure accuracy.</td><td rowspan="2">Carried forward for review at the next inspection</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Warfarin was not prescribed for any residents at the time of this inspection.

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 inspection.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 30

Stated: First time</td><td>The registered person shall ensure that the management of eye preparations is reviewed and revised.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The date of opening had been recorded on eye preparations and records of administration had been maintained.

The deputy manager advised that the management of eye preparations will continue to be monitored as part of the monthly medication audits.</td></tr>
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6.0 What people told us about this home?

In order to reduce footfall in the home, we did not meet with any residents. However, we observed the residents relaxing in the lounge throughout the inspection. The home was decorated for Christmas and residents were joining in with Christmas carols.

Staff were warm and friendly and it was evident from their interactions that they knew the residents well.

We met with one senior care assistant and the deputy 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. 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 deputy manager for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. Three relatives returned questionnaires and all indicated that they were very satisfied with the care provided in the home. One relative commented:

"The owners and staff of Limetree House provide a first class service for my mum especially during Covid 19. Their compassion, care, love and support is wonderful. The owners are very hands on and lead from the front."

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, a pharmacist or during a hospital admission.

Residents in the home were registered with local GPs and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. These are records used to list all 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.

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 are written and updated to check that they are accurate.

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 and pain.

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.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions for two residents. 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 and care plans directing the use of these medicines were available in the medicines file. Records of administration were clearly recorded. The reason for and outcome of administration were recorded.

The management of pain was reviewed. Care plans and records of prescribing and administration were maintained. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required.

7.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine 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.

We reviewed the disposal arrangements for medicines. Discontinued medicines were returned to the community pharmacy for disposal. The disposal book was not reviewed as it was in the community pharmacy on the day of the inspection.

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 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). The sample of these records reviewed indicated that they had been fully and accurately maintained. 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 were recorded in controlled drug record books. The controlled drug record book had been accurately maintained.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. 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 medicines had been given as prescribed.

A small number of residents have their medicines administered in food/drinks to assist administration. The GPs had authorised this practice and care plans detailing how the residents like to take their medicines were in place.

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 reviewed the management of medicines admission process for one resident. A written list of their currently prescribed medicines had been received from their GP. The resident's personal medication record had been verified and signed by two trained staff. Medicines had been accurately received into the home. A small number of minor discrepancies in the administration of their medicines were identified. The audit findings were discussed with the deputy manager who agreed to follow up with staff and closely monitor.

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.

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.

We discussed the medicine related incident which had been reported to RQIA since the last inspection. There was evidence that the incident had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

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.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and six monthly thereafter. A written record was completed for induction and competency assessments.

Records of staff training were available for inspection.

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.

The outcome of this inspection concluded that one area for improvement regarding the management of warfarin was carried forward for review at the next inspection. The remaining area for improvement identified at the last inspection had been addressed.

No new areas for improvement were identified at this inspection. We can conclude that residents were being administered their medicines as prescribed.

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 quality improvement plan (QIP). Details of the QIP were discussed with Mrs Deborah Moore, Deputy Manager, 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:** Second time **To be completed by:** 12 February 2018	The management of warfarin should be reviewed to ensure that staff are able to refer to the original dosage directions at each administration and where transcribing is necessary, a second member of trained staff checks and signs the record to ensure accuracy.
	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 inspection. Ref: 5.0

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

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