Inspection Report
21 October 2020

Seabank

Type of Service: Residential Care Home
Address: 12a Bath Terrace, Portrush BT56 8AN
Tel no: 028 7082 4285
Inspector: Paul Nixon

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 registered residential care home which provides care for up to 37 residents.

2.0 Service details

Organisation/Registered Provider: Seabank Private Residential Home **Responsible Individuals:** Miss Amanda Duncan Mrs Diane Risk	**Registered Manager and date registered:** Ms Charlotte Fiona Simpson 13 April 2018
Person in charge at the time of inspection: Ms Fiona Simpson	**Number of registered places:** 37 Not more than 3 persons in category RC-MP and 1 person in category RC-PH. Maximum of 5 persons in RC-DE category of care
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE – Dementia MP - Mental disorder excluding learning disability or dementia MP (E) - Mental disorder excluding learning disability or dementia – over 65 years PH - Physical disability other than sensory impairment PH (E) - Physical disability other than sensory impairment – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 31

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 21 October 2020 from 09.45 to 12.40.

This inspection focused on medicines management within the service. The inspection also assessed progress with any areas for improvement identified at or since the last medicines management inspection.

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 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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Fiona Simpson, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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

5.0 What has this service done to meet any areas for improvement made at or since the last medicines management inspection on 25 May 2017 and last care inspection on 24 September 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**: Standard 31 **Stated:** First time	The registered provider should ensure that new entries on personal medication records are checked for accuracy and signed by two competent members of staff.	**Met**
	Action taken as confirmed during the inspection: The personal medication records reviewed had been signed by two competent members of staff.	

6.0 What people told us about this service

Some residents were relaxing in the lounges when we arrived in the home. We also observed residents participating in a musical activity in one of the lounges. There was a jovial atmosphere in the home and it was evident that the staff knew the residents well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed

We met with two senior care staff and the registered manager. They 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 also included a staff poster and paper questionnaires which were provided to the registered person for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. No questionnaires were received within the timeframe for inclusion in this report.

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 medical practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times 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 local GP practices and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. These contained a list of all 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, transfers to hospital. The records reviewed had been fully and accurately completed. In line with best practice, a second member of staff checked and signed these records when they were updated to provide a double check that they were accurate.

Copies of residents' prescriptions were retained in the home so that any entry on the personal medication record could be checked against the prescription. This again contributes to confidence that the systems in place are safe.

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, antibiotics, warfarin, modified diets, self-administration etc.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Care plans were in place and directions for use were clearly recorded on the personal medication records.

Satisfactory systems were in place for the management of pain, warfarin and thickening agents.

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

Medicines must be available to ensure that they are administered to residents as prescribed and when they require them. It is important that they are stored safely and securely and disposed of promptly so that there is no unauthorised access.

The records inspected showed that medicines were available for administration when residents required them. The registered manager and senior care staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

On arrival at the home the medicines storage area was observed to be securely locked. It was tidy and organised so that medicines belonging to each resident could be easily located. The medicines currently in use were stored within a medicine trolley that was also securely stored so that there could be no unauthorised access. Controlled drugs were stored in the controlled drug cabinet. When medicines needed to be stored at a colder temperature, they were stored within the medicines refrigerator and the temperature of this refrigerator was monitored.

Medicines disposal was discussed with the registered person and one of the senior care staff. Medicines were returned to the community pharmacy regularly and were not allowed to accumulate in the home. Disposal of medicine records were examined and had been completed so that all medicines could be accounted for.

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 when medicines are administered to a resident. A sample of these records was reviewed which found that they had been fully and accurately completed.

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 a controlled drug record book. We found that controlled drugs were safely managed in the home and that records were accurately maintained.

Medicine administration is audited on a monthly basis within the home. The audits showed that medicines had been given as prescribed. The date of opening was recorded on all medicines so that they can be easily audited. This is good practice.

Audits completed during this inspection also showed that medicines had been given as prescribed.

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 for two residents who had a recent hospital stay and were discharged back to this home. In each instance a hospital discharge letter had been received and a copy had been forwarded to the resident's GP. The resident's personal medication record had been updated to reflect medication changes which had been initiated during the hospital stay. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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 that 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 would help staff to identify medicine related incidents. The registered manager and senior care staff were familiar with the type of incidents that should be reported.

There had been one medication related incident identified since the last medicines management inspection. There was evidence that the incident had been investigated and learning had been shared with staff. The incident had been reported to the prescribers for guidance and to the appropriate authorities including RQIA.

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 that forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

8.0 Evaluation of Inspection

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

The outcome of this inspection concluded that the area for improvement identified at the last medicines management inspection had been addressed and no new areas for improvement

were identified. The registered provider had taken the appropriate actions to ensure that any previous areas for improvement had been addressed and improvements were sustained. We can conclude that residents and their relatives can be assured that medicines are well managed within the home and that residents are getting their medicines.

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

9.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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