Inspection Report

11 May 2023

Seabank

Type of service: Residential Care Home
Address: 12a Bath Terrace, Portrush, BT56 8AN
Telephone number: 028 7082 4285

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: Seabank Private Residential Home **Registered Persons:** Mr William Alexander Duncan Miss Amanda Duncan Mrs Diane Risk	**Registered Manager:** Miss Amanda Duncan **Date registered:** 24 January 2022
Person in charge at the time of inspection: Miss Amanda Duncan	**Number of registered places:** 37 Not more than three persons in category RC-MP and one person in category RC-PH. Maximum of five persons in RC-DE category of care.
Categories of care: Residential Care (RC) PH – physical disability other than sensory impairment MP – mental disorder excluding learning disability or dementia DE – dementia I – old age not falling within any other category 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:** 35
Brief description of the accommodation/how the service operates: Seabank is a registered residential care home which provides health and social care for up to 37 residents. Resident bedrooms are located across three floors and can be accessed via a lift, stairs or chair lift. There are two communal lounges and one dining area situated on the ground floor. An activity area is also located on the first floor.	

2.0 Inspection summary

An unannounced inspection took place on 11 May 2023, from 10.15am to 2.30pm. This was completed by a pharmacist inspector and 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. The area for improvement identified at the last inspection was also reviewed.

Review of medicines management found that robust arrangements were in place for the safe 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 and residents were administered their medicines as prescribed.

The outcome of this inspection concluded that the area for improvement identified at the last inspection had been addressed. No new areas for improvement were identified.

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.

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 to staff and management about how they plan, deliver and monitor the management of medicines.

4.0 What people told us about the service

The inspector met briefly with a number of residents during the inspection. Residents spoke positively about their experience of living in Seabank and were observed to be relaxing in the communal lounge of the home.

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

The inspector also met with senior care staff, the deputy manager 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.

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. At the time of issuing this report, two completed resident questionnaires had been received by RQIA. Both respondents indicated they were 'very satisfied' with the level of care received in Seabank.

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 28th July 2022		
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 29.6 **Stated:** First time	The registered person shall ensure fire drill records evidence the date the fire drill took place, an account of the drill, the name of staff who attended and any actions required.	**Met**
	Action taken as confirmed during the inspection: Fire drill records were maintained and available for review. The records included the date the drill took place, an account of the drill, the name of staff in attendance and any actions required.	

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 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 state that they were 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.

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 were aware that this change may be associated with pain. These medicines were administered infrequently; staff were aware to record the reason and outcome of administration should they be required.

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. Care plans were in place and reviewed regularly.

Some residents may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the resident should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the resident.

The management of thickening agents and nutritional supplements were reviewed. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

The management of warfarin, a high risk medicine, was reviewed. Robust systems must be in place to ensure that blood monitoring is carried out on the specified date and dosage directions are received in writing. This ensures that staff refer to the current dosage directions and warfarin is administered correctly. Safe systems were in place for the management of warfarin. Audits completed by the inspector evidenced that warfarin had been administered as prescribed.

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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. It was observed that some recent temperature recordings of the medicine refrigerator were outside the recommended range of 2^{o}C -8^{o}C. The manager was aware of the recordings and advised a replacement thermometer had been ordered and would be installed once received into the home.

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. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. The records were filed once completed and were readily retrievable for audit/review.

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. There were satisfactory arrangements in place for the management of controlled drugs.

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.

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.

There had been no recent admissions to the home. However, the admission process for new residents or residents returning from hospital was reviewed. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the resident's medicines and this was shared with the community pharmacist.

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.

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 were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. A small number of minor discrepancies were highlighted to the manager for ongoing close monitoring and review.

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. Policies and procedures should be up to date and readily available for staff.

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. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

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

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