Inspection Report
11 November 2020

Karingmore

Type of Home: Residential Care Home
Address: 19 Largy Road, Carnlough BT44 0EY
Tel No: 028 2888 5568
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 16 residents.

2.0 Service details

Organisation/Registered Provider: Karingmore **Responsible Individuals:** Mrs Mary Theresa Hamill & Mr Liam Hamill	**Registered Manager and date registered:** Mrs Mary Theresa Hamill 1 April 2005
Person in charge at the time of inspection: Mrs Mary Theresa Hamill	**Number of registered places:** 16
Categories of care: Residential Care (RC): DE – dementia 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 inspection was undertaken by a pharmacist inspector on 11 November 2020 from 10.55 to 16.30.

This inspection focused on medicines management within the home. It was also to assess the 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 relating to medicines management
- staff training and competency relating to medicines management
- medicine storage temperatures

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	5*	6*

*The total number of areas for improvement includes two standards that have been stated for a second time. One regulation and two standards have been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Mary Hamill, Registered Manager, and one other member of senior staff, 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 management inspection (9 May 2017) and last care management inspection (6 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:** Standard 30 **Stated:** Second time	The registered person shall review the management of distressed reactions to ensure that care plans are in place. The reason for and outcome of each administration should be recorded.	**Carried forward for review at the next inspection**
	Action taken as confirmed during the inspection: At the time of this inspection, these medicines were not currently required and had not been used in some time. Therefore this area for improvement could not be verified and is carried forward for review at the next inspection.	
Area for improvement 2 **Ref**: Standard 31 **Stated:** First time	The registered provider should ensure that the recording of new medicines information on personal medication records involves two staff, and both sign the entry.	**Partially met**
	Action taken as confirmed during the inspection: Two staff are involved in recording new updates on some but not all occasions. Further detail is provided in Section 7.1. This area for improvement has been stated for a second time.	
Area for Improvement 3 **Ref**: Standard 30 **Stated:** First time	The registered provider should put a system in place to ensure that when medicines are not administered in accordance with the prescriber's instructions, this is reported to the prescriber for review and recorded in the residents' notes.	**Met**
	Action taken as confirmed during the inspection: A review of the care records indicated that any issues regarding a resident's compliance with their medicines, was reported to the resident's GP and next of kin.	

Areas for improvement from the last care inspection		
Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 27. – (4) **Stated:** First time	The registered person shall review and action all identified issues as detailed in the fire risk assessment from July 2019. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next inspection.**	**Carried forward for review at the next 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 5.4 & 6.2 **Stated:** Second time	The registered person shall ensure that care records are reviewed and revised to ensure: • Care needs assessments are signed by the resident and/or representative. If the resident or their representative is unable to sign or chooses not to sign, this is recorded. • Specific interventions of the care to be provided are reflected within care plans. **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.**	**Carried forward for review at the next inspection**
Area for improvement 2 **Ref**: Standard 8.5 **Stated:** First time	All care records must be accurate and up-to-date. **Action taken as confirmed during the inspection**: There was limited evidence to indicate that care records included all of the necessary information. See Section 7.1 for further detail. This area for improvement has been stated for a second time.	**Not met**

6.0 What people told us about this home?

We observed residents relaxing in lounges or in their preferred areas, listening to music. We met with two residents. They spoke positively about their care in the home, the food provided and had no concerns regarding their medicines.

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.

We met with the two staff and the manager. Staff expressed satisfaction with how the home was managed and advised us they felt well supported in their role. They also said that they had the appropriate training to look after residents and meet their needs. It was acknowledged that some staff had worked in the home for several years and were familiar with their roles and responsibilities in the organisation and the home.

Feedback methods included a staff poster to direct staff to complete an online questionnaire; 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.

Four staff questionnaires were completed. The majority were recorded as very satisfied or satisfied. Seven resident/relative questionnaires were returned to RQIA, each of these indicated that they were very satisfied or satisfied with the care in Karingmore. In response to the question "Is there anything else that you think we should know about any aspects of your care?" the following comments were made:

- "No, the staff could not do much more."
- "No, nothing."
- "No, everything is good."……
- "No."

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

Personal medication records are records used to list all of the resident's 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.

We identified that these records were not up to date with the most recent prescription and several were incomplete. There were missing dosage directions, it was unclear if some medicines were prescribed or had been discontinued and several of these records required rewriting. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. This need for accuracy was further discussed and was identified as an area for improvement. We also reiterated that two staff should be involved in the writing and updating of these records and both staff should check and

sign that the record is accurate. Whilst this had occurred on some occasions, errors were noted. One area for improvement as stated at the last medicines management inspection has been stated for a second time. It was agreed that obsolete personal medication records would be cancelled and archived.

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. A review of some care plans indicated that they required more information or developed. With reference to pain management, the care plan should state if the resident can express pain, and when the resident is unable to do this, the care plan should detail how their pain is managed. In relation to modified diets, the care plan should detail how the resident should be supported with their food and fluid intake. This had been stated as an area for improvement at the last inspection and is therefore stated for a second time. See also Section 7.4.

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.

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 organised so that medicines belonging to each resident could be located. A medicine refrigerator and controlled drugs cabinet were available for use as needed. Examination of the management of limited shelf life medicines such as eye preparations, found that a number of these had expired and records indicated that they remained in current use. We also highlighted that one inhaled medicine which had an inbuilt dose counter indicated the inhaler was empty – the inhaler should last for 30 days, but was in use for 52 days. An area for improvement was identified.

We reviewed the disposal arrangements for medicines. Discontinued medicines were returned to the community pharmacy for disposal and records maintained.

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. Examination of these records indicated that whilst some were satisfactory, we found that on occasion, staff had used the wrong medicine code, due to copying the codes from the previous day. We also noted missing signatures, which included records regarding topical medicines. This means that medicines may have been administered without a record being made, or the dose had been missed.

These records must be kept fully and accurately maintained and was identified as an area for improvement.

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. This record book should include page numbers and it was agreed this would be addressed.

Medicines administration and controlled drugs were audited daily by staff and the date of opening was recorded on medicines so that they could be easily audited. However, this audit process is very limited as it does not cover all formulations of medicines or all aspects of medicines management. We identified deficits in the medicine system, which had not been noted by staff/management. A robust audit process should be in place which encompasses all areas of medicines management and was identified as an area for improvement.

Whilst the audits completed during the inspection, indicated that the majority of residents were being administered their medicines as prescribed, we noted discrepancies in one inhaled medicine and one liquid medicine. We also noted that one resident had been administered the incorrect dose of a medicine on several occasions; and it was unclear if some medicines were discontinued or the dose had been missed. The manager was requested to report these issues to the resident's GP and forward details of the outcomes to RQIA. An area for improvement was identified. To assist with driving and sustaining improvement it was suggested that the QIP should be used as part of the audit processes.

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 admission process for residents new to the home. There was evidence that staff had been provided with a list of the resident's medicines; however, this list had not been verified with the resident's GP to ensure it was accurate. Two staff were not involved in writing and checking the resident's personal medication record. It was agreed that the resident's GP would be contacted to verify the medicines. An area for improvement was identified. The need for the personal medication records to be accurately written was reiterated.

When a new resident is admitted to the home, in addition to the written confirmation of their medicines and pre-assessments, care plans should be developed in a timely manner. This is necessary to ensure that the staff can deliver the prescribed care. With reference to one resident, there was evidence that the care plans were not in place or were incomplete. This was discussed with the manager for review and improvement; see also Section 7.1.

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.

There have been no medicine related incidents reported to RQIA since 2012. However, the findings of this inspection indicate that the auditing system is not robust and hence incidents may not be identified. It is essential that a robust audit system which covers all aspects of medicines is developed to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff. This has been stated as an area for improvement under Section 7.3.

.

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.

The manager confirmed that the 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 annually thereafter. A written record was completed for induction and competency assessments. The training completed in 2020 included medicines management refresher training, diabetes awareness and infection prevention and control.

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 the outcome of this inspection concluded that residents were being administered their medicines as prescribed, we identified several areas for improvement mainly in relation to governance and record keeping. There was evidence that one area for improvement identified at the last medicines management and care inspections had been fully addressed; however, two areas have not been satisfactorily addressed. This must be reviewed to ensure that there are robust systems in place.

Following the inspection the findings were discussed with the Senior Pharmacist Inspector. As residents were receiving their medicines, it was decided that as a proportionate response, a period of time would be given to implement the necessary improvements. An inspection will be undertaken to determine if the necessary improvements have been implemented and

sustained. Failure to implement and sustain the improvements may lead to enforcement action.

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 Mary Hamill, 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 27 (4) **Stated:** First time **To be completed by:** with immediate effect (6 February 2020)	The registered person shall review and action all identified issues as detailed in the fire risk assessment from July 2019.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next inspection. Ref: 5.0
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that personal medication records are fully and accurately maintained at all times. Ref: 7.1
	Response by registered person detailing the actions taken: This has been actioned. Personal kardex rewritten wjhen required.
Area for improvement 3 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall review the administration of medicines process to ensure that the records of administered medicines are fully and accurately completed. Ref: 7.3
	Response by registered person detailing the actions taken: The administration of medicines process has been reviewed.
Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediately from the date of the inspection	The registered person shall investigate the findings regarding the identified medicines, report these to the prescriber and provide details of the findings and action taken. Ref: 7.3
	Response by registered person detailing the actions taken: This has been actioned and prescriber informed.

Area for improvement 5 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall develop and implement an effective auditing process which covers all formulations of medicines and all aspects of medicines management. Ref: 7.3 & 7.5 **Response by registered person detailing the actions taken:** A more effective auditing process is in progress.
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 8.5 **Stated:** Second time **To be completed by:** Immediate and ongoing	All care records must be accurate and up-to-date. Ref: 5.0 & 7.1 **Response by registered person detailing the actions taken:** Care plans are updated with daily changes in medication and care needs.
Area for improvement 2 **Ref:** Standard 30 **Stated:** Second time **To be completed by**: 9 June 2017	The registered person shall review the management of distressed reactions to ensure that care plans are in place. The reason for and outcome of each administration should be recorded. **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
Area for improvement 3 **Ref:** Standard 5.4 & 6.2 **Stated:** Second time **To be completed by:** With immediate effect (6 February 2020)	The registered person shall ensure that care records are reviewed and revised to ensure: • Care needs assessments are signed by the resident and/or representative. If the resident or their representative is unable to sign or chooses not to sign, this is recorded. • Specific interventions of the care to be provided are reflected within care plans. **Action required to ensure compliance with this standard was not fully reviewed as part of this inspection and this will be carried forward to the next inspection.**
Area for improvement 4 **Ref**: Standard 31 **Stated:** Second time **To be completed by:** Immediate and ongoing	The registered provider should ensure that the recording of new medicines information on personal medication records involves two staff, and both sign the entry. Ref: 5.0 & 7.1 **Response by registered person detailing the actions taken:** This has been implemented.

Area for improvement 5 **Ref**: Standard 32 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall develop a system to check that medicines with a limited shelf-life and medicines with a dose counter are checked and replaced as required. Ref: 7.2 **Response by registered person detailing the actions taken:** This has been actioned. A system has been implemented.
Area for improvement 6 **Ref**: Standard 30 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall review the admission process for new residents to ensure that confirmation of the resident's medicine regime is verified with the prescriber. Ref: 7.4 **Response by registered person detailing the actions taken:** This has been actioned. Staff are aware of the admission process and of the importance of the original medication kardex.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care