Inspection Report

9 March 2023

Naroon House

Type of service: Residential Care Home
Address: 1 Ballyquillan Road, Crumlin, BT29 4DD
Telephone number: 028 9445 2204

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: Naroon House **Responsible Individual:** Miss Mary Kelly	**Registered Manager:** Miss Mary Kelly **Date registered:** 28 August 2015
Person in charge at the time of inspection: Miss Mary Kelly	**Number of registered places:** 12
Categories of care: Residential Care (RC): I – old age not falling within any other category MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years. LD – learning disability LD(E) – learning disability – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 10
Brief description of the accommodation/how the service operates: Naroon House is a registered residential care home which provides health and social care for up to 12 persons. The home is divided over two floors. Residents have access to communal lounges, a dining room and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 9 March 2023, from 10.30am to 2.00pm. 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 areas for improvement identified at the last care inspection have been carried forward for review at the next care inspection.

Review of medicines management found that medicines were stored safely and securely. Medicine related records and care plans were maintained to a largely satisfactory standard. Staff were trained and had been deemed competent to manage medicines. One new area for improvement was identified in relation to medicines audit.

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

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

4.0 What people told us about the service

The inspector met with three residents during the inspection. All of the residents spoke positively of their experience of living in Naroon House. In specific relation to medicines, one resident commented; "medicines are done well and I am very well looked after".

The inspector also met with care staff and the manager. Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well.

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, no questionnaires had been received by RQIA.

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 13 October 2022		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2021)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 3.3. and 3.7 **Stated:** First time	The registered person shall review the pre-admissions process to ensure compliance with the home's statement of purpose, registered categories of care, and regulations and standards. Pre-admission records should be available for inspection.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Area for improvement 2 **Ref:** Standard 5.2 **Stated:** First time	The registered person shall ensure that individual risk assessments are completed and/or reviewed no less than one month following admission to the home.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	

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. However, some of the records had not been checked and signed by a second member of staff when they were written and updated to ensure accuracy. The homes internal audit process did not include regular review of the personal medication records and therefore any errors would not be identified in a timely manner. The manager provided assurances that this would be addressed and included in the audit process moving forward (See Section 5.2.3).

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 three 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 was aware that this change may be associated with pain or infection. Records included the reason for and outcome of each administration.

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 when residents required insulin to manage their diabetes. Insulin was administered by the district nurse and records of administration were maintained.

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. It was identified the order forms used to re-order prescriptions for residents from the GP surgery did not include the date of ordering and these were not signed by the staff member completing the order. This was highlighted to the manager who provided assurances this would be addressed moving forward.

The medicines storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately.

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. However, a small number of discrepancies were identified including the administration of a bisphosphonate medicine. These medicines must be administered separately from food and other medicines as instructed by the manufacturer. There was no regular audit of the medicine administration records and therefore no system in place to identify any discrepancies in the records.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines not supplied in monitored dosage sachets. The date of opening was not consistently recorded on the medicine containers and the administration of some medicines could therefore not be audited. It was evident there was no programme of regular medicine audits. The need for a robust audit system which covers all aspects of medicines is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff. An area for improvement was identified.

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 no controlled drugs in stock on the day of the inspection.

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new residents or residents returning from hospital. Written confirmation of the resident's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

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.

There has been no medicine related incidents reported to RQIA. As stated in Section 5.2.3, a robust audit process is necessary to ensure safe systems are in place and incidents are identified. The manager was reminded that any identified medicine related incident should be reported to RQIA in a timely manner.

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.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with The Residential Care Homes Minimum Standards 2021.

	Regulations	Standards
Total number of Areas for Improvement	0	3*

* The total number of areas for improvement includes two which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Mary Kelly, Registered Manager, as part of the inspection process. The timescale for completion commences from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with Residential Care Homes Minimum Standards 2021	
Area for improvement 1 **Ref:** Standard 3.3. and 3.7 **Stated:** First time **To be completed by:** 10 November 2022	The registered person shall review the pre-admissions process to ensure compliance with the home's statement of purpose, registered categories of care, and regulations and standards. Pre-admission records should be available for inspection.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref:** Standard 5.2 **Stated:** First time **To be completed by:** 10 November 2022	The registered person shall ensure that individual risk assessments are completed and/or reviewed no less than one month following admission to the home.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 3 **Ref:** Standard 30 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (9 March 2023)	The registered person shall implement a robust audit system which covers all aspects of the management of medicines. Ref: 5.2.1, 5.2.3 & 5.2.5
	Response by registered person detailing the actions taken: We have implemented a weekly and monthly audit of medications.

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