The Regulation and Quality Improvement Authority

Inspection Report

4 June 2021

Fairways – Duncreggan

Type of Service: Residential Care Home
Address: Duncreggan, 10 Mark Street, Portrush BT56 8BT
Tel no: 028 7082 4287

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: Fairways Duncreggan Ltd **Responsible Individual:** Mr Robert Anthony Dunlop	**Registered Manager and date registered:** Mrs Sonia Bradley - 1 April 2005
Person in charge at the time of inspection: Mrs Sonia Bradley	**Number of registered places:** 21
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Number of residents accommodated in the residential home on the day of this inspection:** 15

2.0 Inspection summary

An unannounced inspection took place on 4 June 2021, from 10:15am to 1:15pm. The inspection was completed by a pharmacist inspector.

This inspection focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified since the last medicines management 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 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
- RQIA registration certificate

4.0 What people told us about the service

The inspector met with the manager and a senior care assistant. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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

In order to reduce the footfall throughout the home, the inspector met with one resident briefly. The resident did not raise any concerns regarding the care provided and stated they enjoyed living in the home.

Feedback methods included a staff poster and paper questionnaires which were provided to the registered 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, four completed resident questionnaires were returned within the identified timescale. Respondents indicated they were very satisfied with the care received in the home.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

The last inspection of the home was a remote care inspection on 21 September 2020. No areas for improvement were identified at the inspection.

Areas for improvement from the last medicines management inspection on 25 April 2017		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 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 and handwritten entries on printed medication administration records are checked for accuracy and signed by two competent members of staff.	**Not met**
	Action taken as confirmed during the inspection: Handwritten entries on personal medication records and medication administration records were not signed by two members of staff to confirm accuracy. **This area for improvement has been stated for a second time**	

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 will 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, medication reviews or hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. Handwritten entries on personal medication records were not signed by two members of staff. This is good practice to provide a double check that they are accurate. This area for improvement was identified at the previous medicines management inspection and has been stated for a second time.

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, pain, modified diets, self-administration etc.

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. 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. Staff were reminded to consistently document the reason for and outcome of administration in the daily progress notes.

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 for the management of pain were in place for each individual resident requiring pain relief.

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.

We reviewed the management of thickening agents for two residents. A speech and language assessment report and care plan was in place which detailed the recommended consistency level of fluids for each resident. Staff were reminded to also document the recommended consistency level on records of prescribing and administration.

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. A controlled drugs cabinet was available for use as needed.

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

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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs, when medicines are administered to a resident. A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed. Administration of eye drop preparations were recorded on separate MARs. Inspection of these records highlighted one resident had not received an antibiotic eye preparation for three doses. When discussed with the manager, it was stated the eye drops had been administered however had not been signed for as administered by the care staff. Full and contemporaneous records of the administration of medicines must be made at each medicine round. 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 were recorded in a controlled drug record book.

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.

We reviewed the management of medicines for one resident who was admitted to the home for a period of respite care. An accurate list of the resident's prescribed medication had been obtained from the GP surgery and community pharmacy. The resident's personal medication record had been updated and medicines had been accurately received into the home and administered in accordance with the most recent directions. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration. The need for the personal medication record and handwritten MAR to be double signed by two members of staff was reiterated as stated in the area for improvement.

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.

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.

The audits completed by the inspector indicated that the majority of medicines were being administered as prescribed. A few anomalies were highlighted to the manager for 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 that staff are supported. Policies and procedures should be up to date and readily available for staff use.

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.

6.0 Conclusion

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 the area for improvement identified at the last medicines management inspection had not been addressed. One new area for improvement was identified in relation to the administration of eye preparations. Details can be found in the below Quality Improvement Plan.

Whilst we identified areas for improvement, we can conclude that overall, the residents were being administered their medicines as prescribed by their GP, and that the home was well led.

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

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with the Residential Care Homes Minimum Standards (2011).

	Regulations	Standards
Total number of Areas for Improvement	0*	2*

* The total number of areas for improvement includes two under the standards, one which has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Sonia Bradley, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 31 **Stated:** Second time **To be completed by:** 2 July 2021	The registered provider should ensure that new entries on personal medication records and handwritten entries on printed medication administration records are checked for accuracy and signed by two competent members of staff. Ref: 5.1, 5.2.1, 5.2.4
	Response by registered person detailing the actions taken: Medication policy and training refreshed with all staff who administer medication.
Area for improvement 2 **Ref:** Standard 31 **Stated:** First time **To be completed by:** Immediately from the date of inspection	The registered provider should ensure that eye preparations prescribed for residents are administered as prescribed. Records of administration should be fully and accurately completed. Ref: 5.2.3
	Response by registered person detailing the actions taken: Staff advised that they must record all medications and preparations at the point of administration.

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

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