Inspection Report
8 December 2020

Anniscliff House

Type of Home: Residential Care Home
Address: 141 Moneysharvin Road, Maghera, BT46 5HZ
Tel No: 028 7964 2729
Inspector: Rachel Lloyd

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 17 residents.

2.0 Service details

Organisation/Registered Provider: Anniscliff **Responsible Individuals:** Mrs Bernadette McGilligan Mrs J Davies	**Registered Manager and date registered:** Mrs Bernadette McGilligan 1 April 2005
Person in charge at the time of inspection: Mrs Bernadette McGilligan	**Number of registered places:** 17 Not more than one person in category MP. Category of care DE for six identified individuals only and category of care LD (E) for one identified individual only. RC-A for one named resident.
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 LD(E) – learning disability – over 65 years A – past or present alcohol dependence	**Total number of residents in the residential care home on the day of this inspection:** 15

3.0 Inspection focus

This unannounced inspection was undertaken by a pharmacist inspector on 8 December 2020 from 10.35 to 14.00.

This inspection focused on medicines management within the home. The inspection also assessed 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 staff and management about how they plan, deliver and monitor the care and support provided in the home
- 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
- care plans related to medicines management
- governance and audit
- staff training and competency records

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 Bernadette McGilligan, 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 home done to meet any areas for improvement identified at the last care inspection (20 August 2020) and last medicines management inspection (15 May 2017)?

Areas for improvement from the last medicines management 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 13(4) **Stated:** First time	The registered provider must ensure that robust arrangements are in place for the management of external preparations. **Action taken as confirmed during the inspection**: A small number of external preparations were in use, these were recorded on the personal medication record and their administration was recorded on the medicine administration record.	**Met**
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 all updates to personal medication records involves two staff, and both sign the entry. **Action taken as confirmed during the inspection**: This had taken place on most occasions and all personal medication records were signed by two members of staff to verify accuracy. The manager agreed to remind staff that additions should be verified by two staff on every occasion.	**Met**
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time	The registered provider should ensure that written confirmation of medicines regimes is obtained for all new residents. **Action taken as confirmed during the inspection**: The recent admission of two residents was examined. Written confirmation of medicines prescribed was in place and it was evident that this was routine practice.	**Met**

Area for improvement 3 **Ref:** Standard 8 **Stated:** First time	The registered provider should ensure that the reason for and outcome of administration is recorded on each occasion a medicine is administered for distressed reactions.	**Met**
	Action taken as confirmed during the inspection: The management of medication prescribed for distressed reactions was examined for three residents. The reason for and outcome of administration was recorded on each occasion on a record in place for this purpose.	
Area for improvement 4 **Ref:** Standard 30 **Stated:** First time	The registered provider should ensure that any ongoing refusal or non-administration of medicines is reported to the prescriber and recorded in the residents' notes.	**Met**
	Action taken as confirmed during the inspection: The ongoing refusal of medicines was examined and there was evidence that this had been discussed with the prescriber and documented.	

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) (d) (i) **Stated:** First time	The registered person shall ensure that all fire doors are fully closing. Records of the weekly checks should be reviewed to ensure they are effective in identifying any deficits.	**Met**
	Action taken as confirmed during the inspection: The fire doors downstairs were examined and found to be fully closing. There was evidence of weekly checks and several services since the last care inspection.	
Area for improvement 2 **Ref:** Regulation 27(4) (a) **Stated:** First time	The registered person shall ensure that the fire risk assessor is informed in relation to the fire door being propped open at night. Advice should be sought and appropriate action taken in this regard.	**Met**
	Action taken as confirmed during the inspection: The resident to which this was applicable was no	

	longer resident in the home. The manager confirmed that the fire assessor had been consulted at the time and had provided advice to staff.	
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 6.6 **Stated:** First time	The registered person shall ensure that care plans are reflective of the needs of the residents including any recommendations from the multi professional team.	**Met**
	Action taken as confirmed during the inspection: Care plans were examined for three residents prescribed dietary supplements. These matched advice provided by the dietician and/or speech and language therapist and the prescriber.	
Area for improvement 2 **Ref:** Standard 6.2 **Stated:** First time	The registered person shall ensure that a care plan and risk assessment is completed for any resident in the home who smokes.	**Met**
	Action taken as confirmed during the inspection: Arrangements were examined for three residents and a risk assessment and care plan was in place.	

6.0 What people told us about this home?

We met with one senior care assistant and the registered manager. 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. One member of staff was wearing a fabric face mask, this was discussed and the manager agreed this was not appropriate and agreed to take action immediately to ensure disposable fluid resistant surgical masks were worn by staff in accordance with PHA guidelines.

Staff 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 included a staff survey 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, no staff surveys had been completed.

Nine questionnaires were returned from either residents or their representatives (not specified). No comments were provided, but all indicated they were very satisfied with the care received.

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, the pharmacist or during a hospital admission.

Residents in the home were registered with local GPs and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. These are records used to list all 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 e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. Obsolete personal medication records had been cancelled and archived.

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.

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.

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 in place. Records of administration were clearly recorded. The reason for and outcome of administration were recorded.

The management of pain was discussed. Staff were familiar with how each resident expressed their pain and advised that pain relief was administered when required. Care plans were in place.

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 tidy and organised so that medicines belonging to each resident could be easily located. A medicine refrigerator and controlled drugs cabinet were 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.

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 on medicine administration records (MARs). A sample of these records was reviewed. The records were found to have been fully and accurately completed. The completed records were filed once completed.

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 most medicines so that they could be easily audited. This is good practice.

The audits completed during this inspection 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.

The management of medicines during admission to the home was examined for two residents. Arrangements were in place to ensure that staff were provided with a list of medicines from the hospital and this was shared with the resident's GP and the community pharmacist.

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.

We discussed one 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.

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 this forms part of their role. Competency had been assessed following induction and annually thereafter, with one exception this year which the manager agreed to address following the inspection. A written record was completed for induction and competency assessments.

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.

The outcome of this inspection concluded that all areas for improvement identified at the last medicines management and care inspections had been addressed. No new areas for improvement were identified. We can conclude that the residents were being administered their medicines as prescribed.

We would like to thank the 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.

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