The Regulation and Quality Improvement Authority

Inspection Report

24 August 2023

Anniscliff House

Type of service: Residential Care Home
Address: 141 Moneysharvin Road, Maghera, BT46 5HZ
Telephone number: 028 7964 2729

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: Anniscliff **Responsible Individuals:** Mrs Bernadette McGilligan	**Registered Manager:** Mrs Bernadette McGilligan **Date registered:** 1 April 2005
Person in charge at the time of inspection: Mrs Bernadette McGilligan	**Number of registered places:** 17 Including: Not more than one resident in category MP. Category of care DE for six identified residents only.
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	**Number of residents accommodated in the residential care home on the day of this inspection:** 16
Brief description of the accommodation/how the service operates: Anniscliff House is a residential care home registered to provide health and social care for up to 17 residents. The home operates over two floors and all residents have access to communal spaces and an enclosed garden area outside.	

2.0 Inspection summary

An unannounced inspection took place on 24 August 2023 from10.20am to 2.30pm. This was completed by a pharmacist inspector and focused on medicines management.

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.

Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last care inspection would be followed up at the next care inspection.

Review of medicines management found that mostly satisfactory arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered the majority of their medicines as prescribed. One new area for improvement was identified in relation to ensuring that inhaled medicines are administered as prescribed and accurate records maintained.

Whilst an area for improvement was identified, RQIA can conclude that with the exception of this 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 the 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 the manager about how they plan, deliver and monitor the management of medicines within the home.

4.0 What people told us about the service

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

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 four responses had been received by RQIA, from both relatives and residents. These indicated that those who completed them were very satisfied with the care provided, but did not include any additional comments.

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 27 July 2023		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 27 (4) (e) **Stated:** First time	The registered person shall ensure that fire training is completed by all staff twice yearly. **Action taken as confirmed during the inspection**: The manager stated that training was planned with a fire safety professional in attendance. **However, action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**
Area for improvement 2 **Ref:** Regulation 27 (4) (a) **Stated:** First time	The registered person shall ensure that the fire safety risk assessment is reviewed on an annual basis. **Action taken as confirmed during the inspection**: The manager stated that this was planned to take place with a fire safety professional in attendance. **However, action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**
Action required to ensure compliance with Residential Care Homes Minimum Standards (2021)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 29.6 **Stated:** First time	The registered person shall ensure that all staff participate in a fire drill at least annually and the names of the participants is recorded. **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.**	**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. In line with best practice, on the majority of occasions 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. A couple of minor discrepancies were highlighted for amendment. The manager agreed to address these issues immediately following the inspection.

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 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 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. Directions for use were recorded on the personal medication records; and care plans were in place, guidance on ensuring these are specific to each resident, in order to direct staff, was provided. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain. The reason for and outcome of use was

usually recorded, it was acknowledged that these medicines had been administered only occasionally recently.

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 as necessary.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine 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 local prescribers and the community pharmacist and that medicines were supplied in a timely manner.

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. Refrigerated storage and a controlled drugs box were available.

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. The majority of records were found to have been accurately completed. Audits completed during the inspection on inhaled medicines for several residents indicated that administration records were not accurate and that these medicines had not been administered as prescribed. This had not been identified via the home's own audit process. Prescribed medicines must be administered as prescribed and accurate records maintained, including reasons for any omissions. The administration of these medicines should be monitored closely via the home's audit system and compliance issues should be discussed with the resident/reported to the prescriber as necessary. An area for improvement was identified.

Management and staff audited a range of other medicines on a regular basis. The date of opening was recorded on most medicines so that they could be easily audited. This is good practice.

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.

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 and is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff.

No medicine related incidents reported to RQIA since November 2018. Some medicine incidents may not have been identified (see section 5.2.3). The manager agreed to expand the auditing system and report any further discrepancies, audit tools and what must be reported to RQIA were discussed.

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.

Staff had received a structured induction which included medicines management when this forms part of their role. Competency was assessed following induction and then annually thereafter. A written record was completed for induction and competency assessments.

6.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005.

	Regulations	Standards
Total number of Areas for Improvement	3*	1*

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

The new area for improvement and details of the Quality Improvement Plan were discussed with Mrs Bernadette McGilligan, 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 The Residential Care Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 27 (4) (e) **Stated:** First time **To be completed by:** 27 August 2023	The registered person shall ensure that fire training is completed by all staff twice yearly.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Area for improvement 2 **Ref:** Regulation 27 (4) (a) **Stated:** First time **To be completed by:** 27 August 2023	The registered person shall ensure that the fire safety risk assessment is reviewed on an annual basis.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect (24 August 2023)	The registered person shall ensure that prescribed medicines are administered as prescribed and accurate records maintained, including reasons for any omissions. This area for improvement is made regarding inhaler preparations. Ref: 5.2.3
	Response by registered person detailing the actions taken: All staff have been revised on the importance of administering perscribed medicines as perscribed by the GP and to maintain accurate records, including reasons for any omissions. Inhaler preparations will be regularily audited in respect of this.

Action required to ensure compliance with Residential Care Homes Minimum Standards 2021	
Area for improvement 1 **Ref:** Standard 29.6 **Stated:** First time **To be completed by:** With immediate effect (28 July 2023)	The registered person shall ensure that all staff participate in a fire drill at least annually and the names of the participants is recorded. **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.** Ref: 5.1

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