



Inspection Report

29 September 2020



Carmoyne

Type of Service: Residential Care Home
Address: 38 Church Street, Ahoghill, BT42 2PA
Tel No: 028 2587 1439
Inspector: Rachel Lloyd

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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: Carnmoyne Responsible Individual: Mr Benjamin Logan (registration pending)	Registered Manager and date registered: Mrs Emma Logan 30 October 2014
Person in charge at the time of inspection: Mrs Emma Logan	Number of registered places: 16
Categories of care: Residential Care (RC): I - old age not falling within any other category SI - sensory impairment MP(E) - mental disorder excluding learning disability or dementia - over 65 years PH(E) - physical disability other than sensory impairment - over 65 years DE - dementia	Total number of residents in the residential care home on the day of this inspection: 13

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 29 September 2020 from 11.00 to 14.10. Short notice of the inspection was provided the afternoon before the inspection, in order to ensure that arrangements could be made to safely facilitate the inspection in the home.

This inspection focused on medicines management within the home. The inspection also assessed progress with any areas for improvement identified at or since the last medicines management.

Prior to the inspection it was agreed with the senior care inspector that progress in any areas for improvement identified at or since the last care inspection will be assessed at the next care inspection.

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 managing medicines and the registered manager 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:

- training and competency records for staff managing medicines
- personal medication records
- medicine administration
- medicine receipt and disposal
- care plans related to medicines management
- controlled drug record book
- governance and audit records regarding the management of medicines
- medicine storage temperatures

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	*4

*The total number of areas for improvement includes three which 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 Emma Logan, Registered Manager, 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 service done to meet any areas for improvement identified at the last medicines management inspection (17 July 2017) and care inspection (22 November 2019)?

Area 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 8 Stated: First time	The registered person shall ensure that, when a resident is prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the reason for and outcome of administration are recorded.	Met
	Action taken as confirmed during the inspection: Records were examined for two residents and both the reason for and the outcome of administration had been appropriately recorded for these medicines.	
Areas for improvement from the last care 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 6.3 Stated: Second time	The registered person shall ensure that the resident or their representative, where appropriate, sign the care plan along with the member of staff responsible for drawing it up and the registered manager. If the resident or their representative is unable to sign or chooses not to sign, this is recorded.	Carried forward for review at the next care inspection
	Action taken as confirmed during the inspection: This area for improvement was not reviewed at this inspection.	
Area for improvement 2 Ref: Standard 20.3 Stated: First time	The registered person shall ensure that staff annual retention with NISCC is included within the staff registration template so that this can be monitored.	Carried forward for review at the next care
	Action taken as confirmed during the inspection:	

	This area for improvement was not reviewed at this inspection.	inspection
Area for improvement 3 Ref: Standard 23.3 Stated: First time	The registered person shall ensure that update fire safety training is provided twice yearly. The annual fire drill is necessary with a record retained of staff present and outcome.	Carried forward for review at the next care inspection
	Action taken as confirmed during the inspection: This area for improvement was not reviewed at this inspection.	

6.0 What people told us about this service?

We met only briefly with several residents during the inspection, residents appeared content and had warm relationships with staff. Staff interactions with residents were observed to be warm and friendly and staff obviously knew the residents well. A couple of residents had visitors outside in the seating area available, at different times during the inspection. Visitors were observed wearing PPE appropriately and observing social distancing.

We met with one member of staff and the registered manager. This staff member said that the residents were well looked after and expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents, manage their medicines and meet their needs and felt well supported by management and other staff. They said communication within the team was very good.

Feedback methods also 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 envelopes. No questionnaires were completed within the timeframe for inclusion in this report. No staff members completed the online survey.

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 medical practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times 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.

All 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 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/stays. These records had been completed in a satisfactory manner. Although recorded in most cases, staff were reminded to record the date of writing on this record on every occasion. In line with best practice, a second member of staff had checked and signed the records when they were updated to provide a double check that they were accurate.

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 contributes to confidence that the systems in place are safe.

Obsolete records had been archived appropriately. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the resident.

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 etc. Those examined were found to be appropriately maintained.

The management of pain was reviewed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required.

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 refrigerator and controlled drugs cabinet were available.

Discontinued medicines were returned to the community pharmacy for disposal and records were maintained. A small number of medicines that were not in use but had passed their expiry date were removed from stock immediately for disposal.

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, 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. Records were filed once completed.

The audits completed during this inspection showed that medicines had been given as prescribed. A couple of small discrepancies were identified and highlighted for attention. There was no evidence that medicine administration is currently audited within the home, although the date of opening was recorded on most medicines so that they could be easily audited. A robust audit process may have facilitated the identification of the discrepancies noted. Advice was provided and area for improvement was identified (see section 7.5).

One resident was identified as being prescribed an aerosol generating procedure (AGP) with assistance from staff. Staff need to be fit-tested for appropriate PPE to facilitate infection control procedures during this procedure during the Covid-19 pandemic. The registered manager agreed to contact relevant persons responsible for arranging this immediately and to report the outcome in writing to RQIA. It was confirmed that appropriate action had been taken following the inspection.

7.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

Residents 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 admission process for residents new to the home or returning to the home after receiving hospital care was examined. Staff advised that robust arrangements were in place to ensure that they were provided with a list of medicines from the GP and/or hospital and this was shared with the resident's GP and the community pharmacist. Relevant records were accurately written/rewritten.

We examined the medicines prescribed for one recently admitted resident. There were procedures in place to ensure the safe management of medicines during the resident's admission to the home. Written confirmation of medicines from the hospital had been obtained and this was shared with the resident's GP and the community pharmacist. Two members of staff had accurately recorded the medicines prescribed onto the medicine records.

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.

Since no audit system was in place, medicine related incidents may not be identified. Staff were familiar with the type of incidents that should be reported. No medicine related incidents had been reported to RQIA since the last inspection. As discussed in section 7.3 a robust audit system, which covers all aspects of medicines management, 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.

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 manager has a responsibility to check that staff are competent in managing medicines and that staff are supported.

Staff in the home had received an induction which included medicines management when this forms part of their role. Competency had been assessed following induction; however competency assessments had not been reviewed since 2018. The registered manager had identified this and agreed to review these 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 service was well led regarding the management of medicines.

The outcome of this inspection concluded that the area for improvement identified at the last inspection had been addressed and one new area for improvement was identified in relation to audit and governance. We can conclude that, on the basis of the evidence examined, residents were being administered their medicines as prescribed.

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

9.0 Quality Improvement Plan

The area for improvement identified during this inspection is detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Emma Logan, Registered Manager, 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 Action to be taken by the service

The QIP should be completed and detail the actions taken to address the area 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 Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 Ref: Standard 6.3 Stated: Second time To be completed by: 31 January 2020	<p>The registered person shall ensure that the resident or their representative, where appropriate, sign the care plan along with the member of staff responsible for drawing it up and the registered manager. If the resident or their representative is unable to sign or chooses not to sign, this is recorded.</p> <p>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 care inspection.</p>
Area for improvement 2 Ref: Standard 20.3 Stated: First time To be completed by: 31 December 2019	<p>The registered person shall ensure that staff annual retention with NISCC is included within the staff registration template so that this can be monitored.</p> <p>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 care inspection.</p>
Area for improvement 3 Ref: Standard 23.3 Stated: First time To be completed by: 20 December 2019 and ongoing	<p>The registered person shall ensure that update fire safety training is provided twice yearly. The annual fire drill is necessary with a record retained of staff present and outcome.</p> <p>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 care inspection.</p>
Area for improvement 4 Ref: Standard 30 Stated: First time To be completed by: Immediate effect	<p>The registered person shall ensure that a robust auditing system, which covers all aspects of medicines management in the home, is implemented, appropriate action taken when necessary and a record maintained.</p> <p>Ref: 7.3 & 7.5</p> <p>Response by registered person detailing the actions taken: A designated member of staff is carrying out weekly recorded audits, which are then checked by the registered manager.</p>

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



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