Inspection Report
22 October 2020

Clonmore House

Type of Service: Residential Care Home
Address: 22-28 Crossreagh Drive, Rathcoole, Newtownabbey, BT37 9DY
Tel no: 028 9085 1153
Inspector: Paul Nixon

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 42 residents.

2.0 Service details

Organisation/Registered Provider: Northern HSC Trust **Responsible Individual:** Ms Jennifer Welsh - Acting	**Registered Manager and date registered:** Mrs Tracey McCartney – Acting Manager
Person in charge at the time of inspection: Mrs Tracey McCartney	**Number of registered places:** 42 The home is approved to provide care on a day basis only to 2 persons
Categories of care: Residential Care (RC) I - Old age not falling within any other category	**Total number of residents in the residential care home on the day of this inspection:** 14

3.0 Inspection focus

This announced inspection was undertaken by a pharmacist inspector on 22 October 2020 from 09.45 to 11.55. Short notice of the inspection was provided to the manager 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 the areas for improvement idenfied at the last medicines management inspection and three of the six areas for improvement identified at the the last care inspection. Following discussion with the aligned care inspector, it was agreed that the remaining three areas for improvement identified at the last care inspection would be followed up 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 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
- medicine storage temperatures

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	1	0

The area for improvement and details of the Quality Improvement Plan (QIP) was discussed with Mrs Tracey McCartney, 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 home done to meet any areas for improvement identified at the last medicines management inspection (IN028456) on 10 May 2017 and care inspection (IN035593) on 10 January 2020?

Areas 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 31 **Stated:** First time	The registered provider should ensure that all updates to personal medication records and warfarin administration records involves two staff, and both sign the entry.	**Met**
	Action taken as confirmed during the inspection: Updates to personal medication records generally involved two staff, and both signed the entry. No residents were prescribed warfarin.	
Area for improvement 2 **Ref:** Standard 6 **Stated:** First time	The registered provider should ensure that residents' care plans are updated in relation to medicines management.	**Met**
	Action taken as confirmed during the inspection: A selection of care plans were reviewed relating to pain management, the use of thickeners and the management of distressed reactions. The medicines prescribed were stated along with the dosage directions for their use.	
Area for improvement 3 **Ref:** Standard 31 **Stated:** First time	The registered provider should review the management of thickening agents to ensure that robust arrangements are in place.	**Met**
	Action taken as confirmed during the inspection: The records belonging to two residents who were prescribed a thickening agent were reviewed. In each instance a speech and language assessment report and care plan were in place. Records of prescribing and administration which included the recommended consistency level were maintained.	

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 13 (4) (b) **Stated:** First time	The registered person shall ensure that medication is dispensed and administered safely and ensure that medicine which is prescribed is administered to the resident for whom it is prescribed, and to no other resident.	**Met**
	Action taken as confirmed during the inspection: The manager advised that this had been addressed with all senior care assistants involved in the administration of medicines. The senior care assistant confirmed that when medicines are dispensed the person who prepares them ensures that the resident receives and takes them. During the inspection, there was no evidence of any medicines that had been left with residents.	
Area for improvement 2 **Ref:** Regulation 13 (1) (a) and (b) **Stated:** First time	The registered person shall ensure that care is prescribed and delivered so as to make proper provision for the care and where appropriate, treatment and supervision of residents. Residents' care records must reflect that planned care meets assessed resident need.	**Carried forward to the next care inspection**
	Action taken as confirmed during the inspection: **This area for improvement was not reviewed and is carried forward to the next care inspection**.	
Area for improvement 3 **Ref:** Regulation 17 **Stated:** First time	The registered person shall ensure that the governance arrangements in the home are robust and reflect the quality of services and care provided for residents.	**Carried forward to the next care inspection**
	Action taken as confirmed during the inspection: **This area for improvement was not reviewed and is carried forward to the next care inspection**.	

Area for improvement 4 **Ref:** Regulation 29 **Stated:** First time	The registered person shall ensure that the monthly quality monitoring reports are available in the home and are available for residents' and/or other parties to read. The reports should evidence that where a shortfall had been identified the action taken to address the shortfall was detailed.	**Met**
	Action taken as confirmed during the inspection: The monthly quality monitoring reports were available in the home and were available for residents' and/or other parties to read. The reports evidenced that, where a shortfall had been identified, the action taken to address the shortfall was detailed. This area for improvement was, therefore, assessed as met. However, there were no reports of visits by the registered provider since March 2020. The manager advised that during the Covid-19 pandemic period these monthly visits had not taken place. Although we were assured that there was no reduction in the levels of governance within the home, it remained necessary to prepare a written report on a monthly basis and make this available in the home. This was identified as an area for improvement to comply with the Regulations.	
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 29.1 **Stated:** First time	The registered person shall ensure that the current Risk Assessment and Fire Management Plan (recommendations) evidence the action taken to address any recommendation made. The plan should be signed and dated by the manager at the time of taking the necessary action.	**Met**
	Action taken as confirmed during the inspection: The fire management plan evidenced the action taken to address any recommendation made and had been signed and dated by the manager at the time of taking the necessary action.	

Area for improvement 2 **Ref:** Standard 15 **Stated:** First time	The registered person shall ensure that residents have a safe (lockable) place to store their personal items or monies in their bedrooms and that where money is received by staff from a resident or relative a receipt is issued and the appropriate financial records are maintained.	**Carried forward to the next care inspection**
	Action taken as confirmed during the inspection: **This area for improvement was not reviewed and is carried forward to the next care inspection**.	

6.0 What people told us about this home?

We met with the two care staff. They 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.

Staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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. No questionnaires were received by RQIA within the allocate timeframe.

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 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 local 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.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, generally a second member of staff had checked and signed the personal medication records when they were written and updated to provide a double check that they were accurate.

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 record and a care plan directing the use of these medicines was available in the medicines file. These medicines were rarely used.

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.

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 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. 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 when medicines are administered to a resident. A sample of these records was reviewed. The records were found to have been fully and accurately completed.

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 are recorded in a controlled drug record book. These medicines had been appropriately managed.

Management and staff audited medicine administration on a regular basis within the home. A range of audits was carried out. The date of opening was recorded on 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.

We reviewed the management of medicines for two residents who had recently been admitted to the home. Hospital discharge letters had been received and a copy had been forwarded to the residents' GPs. The residents' personal medication records had been accurately written and signed by two staff. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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. 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.

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 they 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. A written record was completed for induction and competency assessments.

Records of staff training in relation to medicines management were available for inspection.

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 in relation to the medicines management.

The outcome of this inspection concluded that robust arrangements were in place for medicines management. We can conclude that the residents were being administered their medicines as prescribed by their GP.

Three of the six areas for improvement identified at the last care inspection were reviewed as met. The remaining three areas for improvement were carried forward for review at the next care inspection. One new area for improvement was identified regarding visits by the registered provider.

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

9.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Tracey McCartney, 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 Actions to be taken by the home

The QIP should be completed and detail the actions taken to address the areas 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 Residential Care Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 13 (1) (a) and (b) **Stated:** First time **To be completed by:** 10 February 2020	The registered person shall ensure that care is prescribed and delivered so as to make proper provision for the care and where appropriate, treatment and supervision of residents. Residents' care records must reflect that planned care meets assessed resident need. Ref: 5.0 **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.**
Area for improvement 2 **Ref:** Regulation 17 **Stated:** First time **To be completed by:** 10 February 2020	The registered person shall ensure that the governance arrangements in the home are robust and reflect the quality of services and care provided for residents. Ref: 5.0 **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.**
Area for improvement 3 **Ref:** Regulation 29 (4) (c) **Stated:** First time **To be completed by:** 22 November 2020	The registered person shall ensure that a visit by the registered provider takes place at least once a month and that a written report on the conduct of the home is prepared and made available in the home. Ref: 5.0 **Response by registered person detailing the actions taken:** Some monitoring visits had been steped down during the pandemic to reduce the footfall in the homes.However, they have recomenced and the August and September monthly report was available on the day of inspection.

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 15 **Stated:** First time **To be completed by:** Immediately	The registered person shall ensure that residents have a safe (lockable) place to store their personal items or monies in their bedrooms and that where money is received by staff from a resident or relative a receipt is issued and the appropriate financial records are maintained. Ref: 5.0
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.

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

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