The Regulation and Quality Improvement Authority

Inspection Report

22 June 2021

Manor Court

Type of service: Residential Care Home
Address: Sloan Street, Lurgan, Craigavon, BT66 8NR
Telephone number: 028 3832 9586

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: Radius Housing Association **Responsible Individual:** Mrs Fiona McAnespie	**Registered Manager:** Ms Carol McCoy **Date registered:** 21 November 2013
Person in charge at the time of inspection: Ms Carol McCoy	**Number of registered places:** 41 The five persons accommodated in the categories RC-LD and RC-LD(E) shall be located in the Respite Unit and one person in category RC-LD (E) within Manor Court. RC-DE category for mild to moderate dementia only.
Categories of care: Residential Care (RC): I - Old age not falling within any other category DE – Dementia MP (E) - Mental disorder excluding learning disability or dementia – over 65 years LD - Learning Disability LD (E) – Learning disability – over 65 years	Number of residents accommodated in the residential care home on the day of this inspection: 33
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 41 residents. The main building provides accommodation for up to 36 persons; Nightingale respite facility provides respite accommodation for up to five persons with learning disabilities	

2.0 Inspection summary

An unannounced inspection took place on 22 June 2021, from 9.30 am to 1.40 pm. This inspection was conducted by a pharmacist inspector and focussed on 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 residents were being administered their medicines as prescribed.

There were robust arrangements for auditing medicines and medicine records were well maintained. Arrangements were in place to ensure that staff were trained and competent in medicines management.

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 previous inspection findings, incidents and correspondence. To complete the inspection we reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines.

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

4.0 What people told us about the service

We met with three members of staff and the manager.

Staff were warm and friendly and it was evident from their interactions that they knew the residents well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The staff members spoken with expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs. They said that the manager was very supportive of staff and readily available to discuss any issues and concerns should they arise.

Feedback methods included a staff poster and paper questionnaires which were provided to the registered manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes.

Five questionnaires were returned. Four respondents indicated that they were satisfied/very satisfied with all aspects of care. One respondent indicate that they were dissatisfied with several aspects of care but did not provide specific details.

5.0 The inspection

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

Areas for improvement from the last inspection on 11 March 2021		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref**: Regulation 5 (1) (a) (b) **Stated:** First time	The registered person shall ensure that each resident is provided with an individual written agreement setting out the terms and conditions of their residency in the home. The agreement must include details of the fees payable, the method of payment and the person by whom the fees are payable. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a future inspection.**	**Carried forward to the next inspection**
Area for Improvement 2 **Ref:** Regulation 30 (1) (f) **Stated:** First time	The registered person shall ensure that any reportable accident in the home is notified to RQIA within the required timescale. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to a future inspection.**	**Carried forward to the next inspection**
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 4.6 **Stated:** First time	The registered person shall ensure that the resident or their representative is given written notice of all changes to the agreement and these are agreed in writing by the resident or their representative. Where the resident or their representative is unable to sign or chooses not to sign, this is recorded. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to a future inspection.**	**Carried forward to the next inspection**

Area for Improvement 2 **Ref:** Standard 27 **Stated:** First time	The registered person shall ensure that improvement is made within the Nightingale unit in regard to the following areas: • Identify a suitable storage space for storage for a day care service user. • Make good the marked wall within the back bedroom. • Replacement of the dining room table cloth.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to a future inspection.	

Areas for improvement from the last medicines management inspection on 15 January 2018		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 31 **Stated:** First time	The registered person shall ensure that the arrangements for recording the use of thickening agents are reviewed.	**Met**
	Action taken as confirmed during the inspection: The arrangements for recording the use of thickening agents had been reviewed. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.	

5.2 Inspection outcome

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 medical 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 and hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, 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.

Copies of residents' prescriptions and 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.

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. The management of these medicines was reviewed. Directions for use were clearly recorded on the personal medication records and, with one exception, care plans directing the use of these medicines were available. Records of administration were recorded, including the reason for and outcome of administration. The manager gave an assurance that a care plan would be written without delay for the applicable resident.

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.

Discontinued medicines were returned to the community pharmacy for disposal and records were 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. The sample of medicine administration records reviewed had been fully and accurately completed.

The audits completed during this inspection showed that medicines had been given as prescribed.

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. Suitable arrangements were in place for the management of controlled drugs.

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 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.

The management of medicines was reviewed for three residents who had a recent respite stay. In each instance, the resident's medication details had been confirmed with their GP. The residents' personal medication records had been accurately written. The medicines had been accurately recorded into and out of the home and administered in accordance with the most recent directions.

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.

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.

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 with respect to the management of medicines.

Based on the inspection findings and discussions held we are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the manager. The residents were being administered their medicines as prescribed by their GP

The area for improvement identified at the last medicines management inspection had been addressed. No new areas for improvement were identified in relation to the management of medicines.

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

7.0 Quality Improvement Plan/Areas for Improvement

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

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

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Ms Carol McCoy, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 5 (1) (a)(b) **Stated:** First time	The registered person shall ensure that each resident is provided with an individual written agreement setting out the terms and conditions of their residency in the home. The agreement must include details of the fees payable, the method of payment and the person by whom the fees are payable.
To be completed by: 23 September 2019	**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 30.(1) (f) **Stated:** Second time **To be completed by:** 12 March 2021	The registered person shall ensure that any reportable accident in the home is notified to RQIA within the required timescale. **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
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 4.6 **Stated:** First time	The registered person shall ensure that the resident or their representative is given written notice of all changes to the agreement and these are agreed in writing by the resident or their representative. Where the resident or their representative is unable to sign or chooses not to sign, this is recorded.
To be completed by: 23 September 2019	**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

Area for improvement 2 **Ref**: Standard 27 **Stated:** First time **To be completed by:** 25 April 2021	The registered person shall ensure the following environmental improvements are addressed: • The refrigerator should be repaired or replaced in the identified bedroom • The skirting board in the identified bathroom should be improved upon.
	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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