Inspection Report
9 September 2020

Sunnymead

Type of Service: Residential Care Home
Address: 12 Portadown Road, Armagh, BT61 9EE
Tel No: 028 3752 3866
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 registered residential care home which provides care for up to 39 residents.

2.0 Service details

Organisation/Registered Provider: Sunnymead (Armagh) Ltd **Responsible Individual:** Ms Linda Margaret Nesbitt	**Registered Manager and date registered:** Mrs Brenda Nesbitt Registered: 24 April 2015
Person in charge at the time of inspection: Ms Dorothy Clarke, Deputy Manager.	**Number of registered places:** Total number of 39 comprising: A maximum of 5 in category RC-MP(E) and a maximum of 5 in category RC-DE. A maximum of 2 in RC-LD (E) and a maximum of 2 in RC-LD. The home is also approved to provide care on a day basis on the condition that the maximum number of service users (39) is not exceeded
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 PH - Physical disability other than sensory impairment	**Total number of residents in the residential care home on the day of this inspection:** 35

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 9 September 2020 from 09.50 to 12.55.

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

A sample of the following records were examined and/or discussed during the inspection:

- medicines management training records and competency assessments
- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drug record book
- care records
- audits

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Dorothy Clarke, Deputy 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 or since the last medicines management inspection on 28 April 2017?

Areas for improvement from the last 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 person should ensure that the arrangements in place to manage changes to prescribed medicines are reviewed and all of the appropriate records are updated in a timely manner.	**Met**
	Action taken as confirmed during the inspection: Several recent medicine changes were reviewed. The changes had been appropriately managed, with the medicine records having been accurately maintained. Procedures are in place to perform a weekly audit of the personal medication record and medicine administration record sheets.	

6.0 What people told us about this service

Observation of the delivery of care evidenced that staff attended to residents needs in a timely and caring manner. Staff were warm and friendly and obviously knew the residents well. The home was observed to be clean and warm; there were no malodours. Corridors were free from trip hazards.

Staff spoken to expressed satisfaction with how the home was managed and with their training opportunities. They said that management was supportive and responsive to any suggestions or concerns raised.

Feedback methods also included a staff poster and paper questionnaires which were provided to the deputy manager for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. Three questionnaires were completed within the timeframe for inclusion in this report. One response stated: “I just feel (my relative) is very well looked after and is happy with her care.”

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 may be done by the GP or the pharmacist.

All residents in the home were registered with local GPs and medicines were reviewed and dispensed by the community pharmacist into a compliance aid from which staff administered medicines.

Personal medication records were in place for each resident. These contained a list of all 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, transfers to hospital. The record reviewed had been fully and accurately completed. In line with best practice, a second member of staff checked and signed these records when they were updated to provide a double check that they were accurate.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Directions for use were clearly recorded on the personal medication records and their use had been appropriately recorded. However, in each instance, a care plan directing their use was not in place; an area for improvement was identified.

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

Medicines must be available to ensure that they are administered to residents as prescribed and when they require them. It is important that they are stored safely and securely and disposed of promptly so that there is no unauthorised access.

The records inspected showed that, with one exception, medicines were available for administration when residents required them. One medicine had been out-of-stock for four days (seven doses). This observation was discussed with the deputy manager who confirmed that the repeat prescription had been requested and the medicine was due to be delivered by pharmacy that day. She agreed to submit an incident notification form to RQIA. The deputy manager advised that there was a good relationship with the community pharmacist and that medicines were generally supplied in a timely manner.

On arrival at the home the medicines storage area was observed to be securely locked. It was tidy and organised so that medicines belonging to each resident could be easily located. The medicines currently in use were stored within medicine trolleys that were also securely stored

so that there could be no unauthorised access. Controlled drugs were stored in the controlled drug cabinet. When medicines needed to be stored at a colder temperature, they were stored within the medicines refrigerator and the temperature of this refrigerator was monitored.

Medicines disposal was discussed with the deputy manager. Medicines were returned to the community pharmacy regularly and were not allowed to accumulate in the home. Disposal of medicine records were examined and had been completed so that all medicines could be accounted for.

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 pre-printed medicine administration records (MARs) when medicines are administered to a resident. A sample of these records was reviewed which found that the records had been fully and accurately completed. The completed MARs are filed once completed.

For three residents, obsolete warfarin dosage directions sheets had not been archived. This is necessary to help ensure that the correct warfarin dose is administered to the resident. The deputy manager gave an assurance that this matter would be rectified immediately.

Manager and senior care staff audit medicine administration on a regular basis within the home. The audits showed that medicines had been given as prescribed. The date of opening was recorded on all medicines so that they can be easily audited. This is good practice.

Audits completed during this inspection also showed that medicines had been given as prescribed (with the exception of the previously referred to medicine that was out-of-stock for seven doses.

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 one recently admitted resident. A hospital discharge letter had been received and a copy had been forwarded to the resident's GP. The resident's personal medication record and medicine administration record sheets had been accurately maintained. Medicines had been administered to the resident in accordance with the prescribed dosage 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 that 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 would help staff to identify medicine related incidents. The deputy manager was familiar with the type of incidents that should be reported.

There had been several medication related incidents identified since the last medicines management inspection. There was evidence that the incidents had been investigated and learning had been shared with staff. The incidents had been reported to the prescribers for guidance and to the appropriate authorities including RQIA.

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 that forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

8.0 Evaluation of Inspection

This inspection sought to assess if the home was delivering safe, effective and compassionate care and if the service was well led with respect to medicines management.

The outcome of this inspection concluded that the registered provider had taken the appropriate actions to ensure that the previous area for improvement had been addressed and that the improvement was sustained.

Although one area for improvement was identified during the current inspection, we can conclude that residents and their relatives can be assured that medicines are well managed within the home.

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 Ms Dorothy Clarke, Deputy 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 service

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 Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)

Area for improvement 1 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 9 October 2020	The registered person shall ensure that, for any resident who is prescribed medication for administration on a “when required” basis as part of the protocol for the management of distressed reactions, a care plan is in place to help direct care. Ref: 6.1
	Response by registered person detailing the actions taken: All relevant careplans have been reviewed to include the protocol of administering PRN medication for the management of distressed reactions.

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

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

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