The Regulation and Quality Improvement Authority

Inspection Report

27 May 2022

Annahilt

Type of service: Residential Care Home
Address: 246 Ballynahinch Road, Annahilt, Hillsborough, BT26 6BP
Telephone number: 028 9263 8399

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: Tamulst Care Limited **Responsible Individual:** Mrs Natasha Southall	**Registered Manager:** Ms Naomi Graham **Date registered:** 17 February 2010
Person in charge at the time of inspection: Ms Naomi Graham	**Number of registered places:** 36
Categories of care: Residential Care (RC): I – old age not falling within any other category DE – dementia A – past or present alcohol dependence	**Number of residents accommodated in the residential care home on the day of this inspection:** 12
Brief description of the accommodation/how the service operates: This is a residential care home with 36 beds that provides care for residents with a range of care needs.	

2.0 Inspection summary

An unannounced inspection took place on 27 May 2022, from 10.00am to 1.30pm. This was completed by two pharmacist inspectors.

The inspection focused on medicines management within the home. 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.

The outcome of this inspection concluded that robust arrangements were not in place for all aspects of medicines management. One new area for improvement has been identified as detailed in the report and QIP.

Whilst one area for improvement was identified, RQIA can conclude that overall, the residents were being administered their medicines as prescribed. Medicine records were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines.

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 this 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. Staff views were also obtained.

4.0 What people told us about the service

Residents were observed to be relaxing in the dining area.

Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well.

The inspector also met with senior care staff, the deputy manager and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs.

Feedback methods included a staff poster and (easy read for LD) 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, no questionnaires had been received by RQIA.

5.0 The inspection

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

The last care inspection to this residential care home was undertaken on 18 January 2022 by a Care inspector; no areas for improvement were identified.

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, 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.

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.

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 medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed. Directions for use were clearly recorded on the personal medication record. A care plan was in place for behavioural management but did not specify the prescribed medication and directions for its use. Staff knew how to recognise a change in a resident's behaviour and was aware that this change may be associated with pain.

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 and reviewed regularly, however one care plan reviewed did not reflect the current medication regimen.

An area for improvement was identified to ensure that care plans are fully and accurately maintained.

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 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. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

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. Most of the records were found to have been fully and accurately completed. The records were filed once 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 should be recorded in the controlled drug record book. On one occasion a resident was transferred to another care home. The transfer of their controlled drugs was accurately documented in the drug returns/disposal book and signed by two members of staff but the controlled drug record book had not been updated to reflect this. This was discussed with the manager.

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 all 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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new residents. Written confirmation of the resident's medicine regime was obtained from their GP at or prior to admission and the 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.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed.

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.

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 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 Minimum Standards 2021.

	Regulations	Standards
Total number of Areas for Improvement	0*	1*

The area for improvement and details of the Quality Improvement Plan were discussed with Ms Naomi Graham, 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 Residential Care Homes Minimum Standards 2021

Area for improvement 1 **Ref:** Standard 6 **Stated:** First time **To be completed by:** From the date of the inspection onwards	The responsible person shall ensure that care plans are fully and accurately maintained and updated with particular reference to: • the management of medicines prescribed on a "when required" basis for distressed reactions • the management of pain. Ref: 5.2.1
	Response by registered person detailing the actions taken: The care plans referred to in this standard have been updated as discussed on the day of the inspection. Care Plan training has been arranged for members of the care team.The purposed date for this training is the 5th August. Going forward when the Home Manager reviews the monthly medication audit she will review the care plans listed above.

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

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