Inspection Report

1 August 2022

Balloo House Care Home

Type of service: Residential Care Home
Address: 40 Donaghadee Road, Groomsport, BT19 6LH
Telephone number: 028 9146 4430

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: Balloo House Care Ltd **Responsible Individual:** Mrs Shirley Ann Ramrachia	**Registered Manager:** Miss Caoimhe McClelland **Date registered:** 2 July 2020
Person in charge at the time of inspection: Miss Caoimhe McClelland	**Number of registered places:** 30
Categories of care: Residential Care (RC): I – old age not falling within any other category DE – dementia SI – sensory impairment	**Number of residents accommodated in the residential care home on the day of this inspection:** 27
Brief description of the accommodation/how the service operates: Balloo House Care Home is a residential care home which is registered to provide care for up to 30 residents.	

2.0 Inspection summary

An unannounced inspection took place on 1 August 2022, from 10.20am to 3.35pm. The inspection was completed by a pharmacist inspector.

The inspection focused on medicines management within the home and assessed progress with the area for improvement identified at the last inspection.

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.

Review of medicines management found that the majority of medicines were administered as prescribed. However, improvements in record keeping, the storage of medicines and governance and audit were necessary. The registered manager forwarded an action plan and copy of the home's revised audit tool to RQIA following the inspection. Once completed and embedded into practice this should improve practice and improve the management of medicines within the home.

The outcome of this inspection concluded that robust arrangements were not in place for all aspects of medicines management. Four new areas for improvement have been identified as detailed in the report and Quality Improvement Plan. Following the inspection the findings were discussed with the Senior Pharmacist Inspector (RQIA). It was decided that a period of time would be given to implement the necessary improvements. A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained. Failure to implement and sustain the improvements may lead to enforcement.

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 the home was 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. To complete the inspection the following were 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. The inspector spoke with staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with the two senior carers, the head of care and the registered manager.

Staff were warm and friendly and it was evident from discussions 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 and the training received. They said that the team communicated well and the manager was 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 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, three questionnaires were returned to RQIA. The respondents indicated that they were satisfied/very satisfied with all aspects of the care provided.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last inspection on 26 May 2022?

Action required to ensure compliance with Residential Care Homes Minimum Standards (2021)		Validation of compliance
Area for Improvement 1 **Ref:** Standard 13 **Stated:** First time	The registered person shall ensure that the programme of activities is displayed in a suitable format in an appropriate location in order that residents know what is scheduled and a record is kept of all activities that take place, the person leading the activity and the names of the residents who participate or decline to participate in the planned activity.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has now been met.	

5.2 Inspection findings

5.2.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in residential care homes should be registered with a general 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 a GP, a 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.

Some of the personal medication records were not up to date with the most recent prescriptions. In addition, they had not been verified and signed by two staff to ensure accuracy at the time of writing and at each update. Obsolete personal medication records were available on the medicine file. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional.

The registered person should ensure that the personal medication records are:

- accurate and up to date,
- verified and signed by two staff at the time of writing and at each update, and,
- obsolete personal medication records are cancelled and archived

An area for improvement was identified.

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 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 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 distressed reactions was reviewed. 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, infection or constipation. Care plans directing the use of these medicines were available and directions for use were clearly recorded on the personal medication records. Records of administration were accurately maintained. The reason for and outcome of administration were recorded on most occasions. It was agreed that this would be monitored as part of the planned increased audit activity.

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.

Some residents may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the resident should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the resident.

The management of thickening agents was reviewed. Speech and language assessment reports and care plans were in place. Systems were in place to ensure that thickening agents were administered as prescribed. However, records of prescribing and administration were not maintained. These were updated immediately following the inspection and assurances were provided that they would be monitored as part of the increased audit activity.

There was evidence that staff took appropriate action when residents were non-compliant with their prescribed medicines. Care plans were in place and there was evidence of multi-disciplinary team involvement.

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.

Medicines must be stored securely to ensure that access is limited to authorised staff. Storage was tidy and organised so that medicines belonging to each resident could be easily located. However, medicines were not stored securely on the day of the inspection. Broken locks were observed on one medicine cupboard and a medicine trolley. The manager confirmed via email that this was addressed immediately after the inspection and that on-going compliance will be monitored daily.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained at all times it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. Only the current temperature of the medicines refrigerator was monitored each day; this does not provide assurance that the required temperature range is maintained at all times. The registered person must ensure the maximum and minimum refrigerator temperature is monitored each day and the thermometer reset. Corrective action must be taken if temperatures outside the required range are observed. An area for improvement was identified.

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 and were readily retrievable for audit and review. Staff were reminded that all hand-written updates should be verified and signed by a second member of staff to ensure accuracy of transcription. It was agreed that records for the administration of 'when required' creams, shampoos, analgesics, laxatives would be reviewed to ensure that it was clear when the medicines were administered.

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. There were satisfactory arrangements in place for the management of controlled drugs. Records were maintained to the required standard.

The majority of medicines were supplied in a monitored dosage system. The audits completed on these medicines showed that they had been administered as prescribed.

However, discrepancies in a number of medicines which were supplied in their original packs were observed.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out, including running stock balances for medicines which were supplied in their original containers, including antibiotics. A review of four recently prescribed antibiotics indicated that doses had been omitted in error. This was evident from the running stock counts but staff had not highlighted the errors to their colleagues or management. The registered person must review the auditing systems to ensure that when errors are identified they are escalated to management for investigation, reporting to the prescriber for guidance and the appropriate authorities, including RQIA. The auditing system should be further developed to include all aspects of the management of medicines, including those identified at this inspection. Two areas for improvement were identified.

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 mostly satisfactory arrangements were in place to manage medicines for residents new to the home or returning from hospital. Written confirmation of the resident's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. However, as identified in Sections 5.2.1 and 5.2.2, personal medication records and hand-written medication administration records had not been verified and signed by two staff to ensure accuracy; this should be addressed and monitored through the audit process. See Section 5.2.1, 5.2.2 & 5.2.3.

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.

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.

As detailed in Section 5.2.3 a number of medication related incidents were identified at the inspection and were apparent to staff who administer medicines from the daily running stock balances. These had not been reported to the prescriber for guidance or to the management team for investigation. The management team advised that all staff would receive guidance on the action to be taken when they identify a discrepancy in the administration of medicines. As

detailed above, a review of the monthly management audits indicated that the issues raised at this inspection were not being identified. See Section 5.2.3

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. Policies and procedures should be up to date and readily available for staff.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision and at annual appraisal. Medicines management policies and procedures were in place.

It was agreed that the findings of the inspection would be discussed with all staff to ensure that the necessary improvements are implemented. A staff meeting was arranged following the inspection.

6.0 Quality Improvement Plan/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.

	Regulations	Standards
Total number of Areas for Improvement	4	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Caoimhe McClelland, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure the personal medication records are accurately maintained and, verified and signed by two members of staff. Ref 5.2.1 & 5.2.4 **Response by registered person detailing the actions taken:** The personal medication records have been updated and reviewed by two members of staff to ensure records are accurately maintained.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure the maximum and minimum refrigerator temperatures are monitored each day and the thermometer reset. Corrective action must be taken if temperatures outside the required range are observed. Ref: 5.2.2 **Response by registered person detailing the actions taken:** A new medical fridge thermometer is now in place to monitor and document the maximum and minimum temperatures each day. The thermometer is reset daily and spotchecks are undertaken.
Area for improvement 3 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that when errors are identified they are escalated to management for investigation, reported to the prescriber for guidance and the appropriate authorities, including RQIA. Ref: 5.2.3 & 5.2.5 **Response by registered person detailing the actions taken**: Medicine staff have been reminded of their responsibility in medicine administration to identify and report errors to the prescriber for guidance and appropriate authorities including RQIA. Management have revised the audit template and regular audits on medication are completed.

Area for improvement 4 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall further develop the audit process to include all aspects of the management of medicines, including those identified at this inspection. Action plans to address any shortfalls identified should be implemented. Ref: 5.2.1, 5.2.3, 5.2.4 & 5.2.5
To be completed by: From the date of inspection	**Response by registered person detailing the actions taken**: Following the inspection the homes audit tool has been revised and action plans are in place. Progress is closely monitored by management.

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

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