Inspection Report
6 August 2020

The Beeches Professional & Therapeutic Services

Type of Service: Residential Care Home
Address: 41 Lisburn Road, Ballynahinch BT24 8TT
Tel No: 028 9756 1800
Inspector: Paul Nixon

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 34 residents. The home is divided into four cottages with individual dining rooms and communal rooms for residents.

2.0 Inspection focus

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

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.

The following records were examined and/or discussed during the inspection:

- RQIA registration certificate
- the care records for two residents requiring a modified diet
- the care records for three residents prescribed medication for administration on a “when required” basis for the treatment of distressed reactions
- staff medicines management training and competency assessment records
- personal medication records
- medicine administration records
- medicine receipt and disposal records

- controlled drug record book
- audits.

3.0 Service details

Organisation/Registered Provider: The Beeches Professional & Therapeutic Services Ltd **Responsible Individual:** Mr James Brian Wilson	**Registered Manager and date registered:** Mrs Siobhan Duffy 25 July 2019
Person in charge at the time of inspection: Ms Mandy Mason (Deputy Manager) until 11.00, then Ms Carol Gaskin (Deputy Manager)	**Number of registered places:** 34
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 32

4.0 What has this service done to meet any areas for improvement made at or since the last medicines management and care inspections on 6 February 2018 and 7 November 2019?

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 30 **Stated:** First time	The registered person shall ensure that a robust auditing system is developed and implemented.	**Met**
	Action taken as confirmed during the inspection: A robust auditing system had been developed and implemented. Daily, weekly and monthly medicine audits were carried out and any issues arising were appropriately addressed.	

Areas for improvement from the last care 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 35 **Stated:** First time	The registered person shall consider in conjunction with the regional infection prevention and control guidelines the provision of hand sanitising gel throughout the home.	**Met**
	Action taken as confirmed during the inspection: Hand sanitising gels were distributed throughout the home and wall mounted dispensers had been installed in key locations.	

5.0 What people told us about this service

On the day of inspection we spoke to several staff on duty. 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.

Good interactions were observed between staff and residents. Staff were warm and friendly and knew the residents well.

Feedback methods also included a staff poster and paper questionnaires which were provided to the registered person for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. Four questionnaires were completed within the timeframe for inclusion in this report. One respondent stated, “I am very happy with the care my relative gets at The Beeches.”

5.1 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.

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 records examined had all been fully and accurately completed. In line with best practice, a second member of staff had checked and signed these records when they were updated to provide a double check that they were accurate.

Copies of residents' prescriptions were retained in the home so that any entry on the personal medication record could be checked against the prescription. This again contributes to confidence that the systems in place are safe.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Care plans were in place and directions for use were clearly recorded on the personal medication records. The reason for and outcome of the administration were recorded in the daily care records.

Satisfactory systems were in place for the management of thickening agents.

5.2 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 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.

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 one of the deputy managers, who advised that they 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 medicines could be accounted for.

5.3 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 medicine administration records were reviewed which found that they had been fully and accurately completed. The completed records were filed once completed.

Management and staff audit medicine administration on a regular basis within the home. A range of daily, weekly and monthly audits were performed. The audits showed that medicines had been given as prescribed. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

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

5.4 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 resident who had a recent hospital stay and was discharged back to this home. A hospital discharge letter had been received and a copy had been forwarded to the resident's GP. The resident's personal medication record had been updated to reflect medication changes which had been initiated during the hospital stay. Medicines had been accurately received into the home and administered in accordance with the most recent directions. There was evidence that staff had followed up issues identified in the discharge information with the hospitals and GPs, to ensure that medicines were available for administration and administered as prescribed.

5.5 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. The deputy managers were familiar with the type of incidents that should be reported.

There had been a small number of 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.

5.6 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.

6.0 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.

The outcome of this inspection concluded that all areas for improvement identified at the last medicines management and care inspections had been addressed and no new areas for improvement were identified.

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.

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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