Inspection Report
3 December 2020

Camlo Homes

Type of Service: Residential Care Home
Address: 3-5 North Parade, Belfast BT7 2GF
Tel No: 028 9064 5127
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 32 residents.

2.0 Service details

Organisation/Registered Provider: Camlo Homes **Responsible Individual:** Mr Stephen Emerson	**Registered Manager and date registered:** Mrs Joanne Smart 1 April 2005
Person in charge at the time of inspection: Mrs Joanne Smart	**Number of registered places:** 29
Categories of care: Residential Care (RC) MP - Mental disorder excluding learning disability or 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 PH (E) - Physical disability other than sensory impairment – over 65 years A – Past or present alcohol dependence.	**Total number of residents in the residential care home on the day of this inspection:** 22

3.0 Inspection focus

This announced inspection was undertaken by a pharmacist inspector on 3 December 2020 from 09.40 to 12.30.

Short notice of the inspection was provided to the registered manager in order to ensure that arrangements could be made to safely facilitate the inspection in the home.

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 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 was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drug records
- care plans related to medicines management
- governance and audit
- staff training and competency records
- medicine storage temperatures
- RQIA registration certificate

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Joanne Smart, Registered Manager and Mr Grant Johnston-Wood, Deputy Manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

5.0 What has this service done to meet any areas for improvement made at or since the last medicines management inspection on 3 July 2017 and last care inspection on 9 January 2020?

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 8 **Stated:** Second time	The management of medicines prescribed on a "when required" basis for the management of distressed reactions should be reviewed and revised to ensure that all appropriate records are maintained.	**Met**
	Action taken as confirmed during the inspection: The management of medicines prescribed on a "when required" basis for the management of distressed reactions had been reviewed and revised to ensure that all appropriate records are maintained. Care plans were in place. These medicines were rarely used.	
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time	The registered person shall ensure that the procedures for the management of medicines during a resident's admission to the home are reviewed.	**Met**
	Action taken as confirmed during the inspection: The admission/readmission process for three residents was examined. Robust arrangements were in place. Hospital discharge letters or written confirmation from the GP practice had been received. The residents' personal medication records had been accurately written or updated to reflect medication changes and had been signed by two staff members.	

There were no areas for improvement identified at the last care inspection.

6.0 What people told us about this service

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.

Feedback methods included a staff poster and paper questionnaires which were provided to the registered 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.

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 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 local 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 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 e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were mostly accurate and up to date. Several residents did not have their drug allergy status specified; the registered manager gave an assurance that this matter would be rectified immediately. 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.

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, self-administration 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 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.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. 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. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available in the medicines file. These medicines were rarely used.

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. Pain management 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. We reviewed the management of thickening agents and nutritional supplements for one resident. A speech and language assessment report and care plan was in place. However, records of prescribing and administration which included the recommended consistency level were not maintained; this was rectified by the registered manager during the inspection.

7.2 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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

We reviewed the disposal arrangements for medicines. Discontinued medicines were returned to the community pharmacy for disposal and records maintained.

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 medicine administration records when medicines are administered to a resident. A sample of these records was reviewed and were found to have been fully and accurately completed. The completed 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 were recorded in controlled drug record books.

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.

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

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.

The admission/readmission process for three residents was examined. Robust arrangements were in place. Hospital discharge letters or written confirmation from the GP practice had been received. The residents' personal medication records had been accurately written or updated to reflect medication changes and had been signed by two staff members. Medicines had been accurately received into the home and administered in accordance with the most recent 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 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. There had been no medicine related incidents reported to RQIA since the last inspection; however, management were familiar with the type of incidents that should be reported.

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

8.0 Evaluation of Inspection

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

The outcome of this inspection concluded that all areas for improvement identified at the last medicines management inspection had been addressed. No new areas for improvement were identified. We can conclude that the residents were being administered their medicines as prescribed by their GP.

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

9.0 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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