Inspection Report
8 December 2020

Carmen House

Type of Service: Residential Care Home
Address: 3 Carmen Lane, Bangor, BT20 3PL
Tel No: 028 9145 9508
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 15 residents.

2.0 Service details

Organisation/Registered Provider: Carmen House **Responsible Individual:** Mr Alexander Thomas Millar	**Registered Manager and date registered:** Mrs Wendy Carson 10 July 2019
Person in charge at the time of inspection: Mrs Wendy Carson	**Number of registered places:** 15 Maximum of two residents in RC-DE (mild dementia) category of care and one resident in RC-PH.
Categories of care: Residential Care (RC) I - Old age not falling within any other category DE - Dementia PH - Physical disability other than sensory impairment	**Total number of residents in the residential care home on the day of this inspection:** 10 (in addition, three residents were in hospital)

3.0 Inspection focus

This announced inspection was undertaken by a pharmacist inspector on 8 December 2020 from 09.35 to 11.55.

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 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 was examined and/or discussed during the inspection:

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

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	2*	1

*The total number of areas for improvement includes one that has been stated for a second time under the Regulations.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Wendy Carson, Registered 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 made at or since the last medicines management inspection on 8 October 2019?

Areas for improvement from the last medicines management inspection		
Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** First time	The registered person shall ensure that the procedure for administering medicines is reviewed to ensure that the medicine administration record is completed by the staff member immediately after administering medicines to the resident.	**Met**
	Action taken as confirmed during the inspection: The medicine administration records had been completed to a high standard.	
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered person shall ensure that the management of controlled drugs is reviewed to ensure that clear and accurate records are maintained and that handover stock balance checks are accurately performed.	**Not met**
	Action taken as confirmed during the inspection: The receipts of several controlled drugs had not been entered into the controlled drugs record book, with the result that the running stock balances recorded were incorrect. Handover stock balance checks had not, therefore, been accurately performed. **This area for improvement is stated for a second time**.	
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First time	The registered person shall ensure that a medicines management competency assessment is performed and recorded before a staff member is delegated the responsibility for administering medicines.	**Met**
	Action taken as confirmed during the inspection: Competency assessments had been performed and recorded before staff members were delegated the responsibility for administering medicines.	

6.0 What people told us about this service

We met with two care staff and the registered manager. Staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed. Staff were warm and friendly and it was evident from their interactions that they knew the residents well.

Staff 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.

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, four questionnaires had been received by RQIA. The respondents indicated they were very satisfied with all aspects of 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 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 local GPs 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 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 provide a double check 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.

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 a care plan directing the use of these medicines was available. Records of administration were clearly recorded. The reason for and outcome of administration were generally recorded in the daily progress notes.

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.

Several residents self-administered inhalers or topical medicines. Risk assessments covering these arrangements were not in place. Residents who self-administer their own medicines should have had the risks assessed and their competence to self-administer confirmed. 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 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. The registered manager advised that there was 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 controlled drugs cabinet was 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 pre-printed medicine administration records or occasionally handwritten medicine administration records, when medicines are administered to a resident. A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed. The completed records were filed once completed.

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 not dispensed in the monitored dosage system sachets so that they could be easily audited. This is good practice. The need for the registered manager to closely monitor the completion of the controlled drugs record book was emphasised.

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.

There had been no recent admissions to the home. However, we discussed the admission process for residents new to the home or returning to the home after receiving hospital care. Staff advised that robust arrangements were in place to ensure that they were provided with a list of medicines from the hospital and this was shared with the resident's GP and the community pharmacist.

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. Management and staff were familiar with the type of incidents that should be reported.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. 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.

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 annually thereafter. A written record was completed for induction and competency assessments.

However, staff needed to be provided with further training in relation to the management of controlled drugs, specifically in relation to recording and stock balance checks (see Section 5.0). An area for improvement was identified.

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 in respect of the management of medicines.

The outcome of this inspection concluded that improvements in several areas of the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan and include the management of controlled drugs and risk assessments for residents who self-administer medicines.

Two of the three areas for improvement identified at the last medicines management inspection had been addressed. One area for improvement was not addressed and is stated for a second time. Two new areas for improvement were identified.

Whilst we identified areas for improvement, 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

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Wendy Carson, Registered 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** Second time **To be completed by:** Immediate, from the inspection date onwards	The registered person shall ensure that the management of controlled drugs is reviewed to ensure that clear and accurate records are maintained and that handover stock balance checks are accurately performed. Ref: 5.0
	Response by registered person detailing the actions taken: All staff have been made aware of the procedures on handover and stocks; the importance of ensuring the CD book is accurate and checked over on each shift. The importance of new CD medication being entered into the control book on arrival on premises.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 8 January 2021	The registered person shall ensure that staff receive further training in relation to the management of controlled drugs, specifically in relation to recording and stock balance checks. Ref: 7.6
	Response by registered person detailing the actions taken: RM has gone over the procedures with all staff about the importance of CD medications and the recording and stock blance checks. RM has contacted the Pharmacy and they are going to provide additional training in the near future. CD audits will be ongoing.
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 33 **Stated:** First time **To be completed by:** 8 January 2021	The registered person shall ensure that residents who self-administer their own medicines have a risk assessment in place and their competence to self-administer confirmed. Ref: 7.1
	Response by registered person detailing the actions taken: All put in place and placed in their care plan.

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

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