The Regulation and Quality Improvement Authority

Inspection Report

17 May 2021

Lawnfield House

Type of service: Residential Care Home
Address: 5 King Street, Newcastle, BT33 0HD
Telephone number: 028 4372 6860

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: Presbyterian Council of Social Witness **Responsible Individual:** Mr Lindsay Conway	**Registered Manager:** Mrs Andrea McComiskey **Date registered:** Acting
Person in charge at the time of inspection: Mrs Andrea McComiskey	**Number of registered places:** 20
Categories of care: Residential Care (RC): I – old age not falling within any other category 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 SI – sensory impairment	**Number of residents accommodated in the residential care home on the day of this inspection:** 10
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 20 residents. The home was not open for respite care at the time of this inspection.	

2.0 Inspection summary

An unannounced inspection took place on 17 May 2021 between 10.35am and 1.40pm. The inspection was completed by a pharmacist inspector.

This inspection focused on medicines management within the home.

Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last care inspection would be followed up at the next care inspection.

A review of how medicines were managed in the service found that safe systems were in place and no areas for improvement were identified. Medicine records were fully completed, medicines were stored safely and arrangements were in place to ensure that staff were trained and competent in medicines management.

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 we reviewed information held by RQIA about this home. This included previous inspection findings, incidents and correspondence. To complete the inspection we 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.

During our inspection we:

- spoke to residents
- 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 records
- medicine receipt records
- care plans related to medicines management
- governance and audit
  staff training and competency records

4.0 What people told us about the service

Residents were observed to be relaxing in the lounge and participating in various activities. One resident was enjoying the sunshine in the garden.

We spoke with two residents. One resident was discussing the change of bedroom and said that their favourite thing about the home was the view of the sea and mountains. They said that the staff in the home were helpful and they enjoyed living there.

Staff were warm and friendly and it was evident from their interactions that they knew the residents well.

We met with the one senior care assistant and the manager. 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 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, one questionnaire had been received by RQIA which recorded that the respondent was very satisfied with the care provided.

5.0 The inspection

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

Areas for improvement from the last care inspection on 19 January 2021		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for Improvement 1 **Ref**: Standard 6.6 **Stated:** Second time	The registered person shall ensure that risk assessments for residents are reviewed on a regular basis or when any change occurs. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**
Area for improvement 2 **Ref**: Standard 23 **Stated:** First time	The registered person shall ensure that a system is developed to maintain staffs' compliance with mandatory training. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**
Area for improvement 3 **Ref**: Standard 28.3 **Stated:** First time	The registered person shall ensure that any defects reported are managed in a timely manner. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**

Area for improvement 4 **Ref**: Standard 24.5 **Stated:** First time	The registered person shall ensure that a system is developed to ensure all care staff receives an annual appraisal. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**
Area for improvement 5 **Ref**: Standard 6.3 **Stated:** First time	The registered person shall ensure that all residents' care records are signed and dated by the person creating the record for use. Any record no longer valid should be discontinued; signed, dated and archived. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**
Area for improvement 6 **Ref**: Standard 20.10 **Stated:** First time	The registered person shall ensure that an effective care record audit tool is developed and implemented to monitor record keeping practices in the home. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**

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 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 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 provide a double check that they are accurate. A small number of medicines had not been cancelled from the record when they had been discontinued. This was highlighted to the manager who agreed to address this immediately after the inspection.

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.

We reviewed the management of thickening agents for two residents. A speech and language assessment report and care plan was in place. Records of prescribing and administration were maintained. The manager was reminded that the administration records should have the consistency recorded and it was agreed that this would be done after the inspection.

Residents were supported to self-administer medicines where this was their preference.

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.

The records inspected showed that medicines were available for administration when residents required them. The manager 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.

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.

Within the home, a record of the administration of medicines was completed. A sample of these records was reviewed. All of the records were found to have been fully and accurately completed. Records were filed once completed.

Management and staff audited medicine administration on a regular basis within the home. Good outcomes were observed. A range of audits were carried out by the inspector and correlated with the findings of the manager's audits. 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.

The admission process for residents new to the home or returning to the home after receiving hospital care was discussed. The manager advised of the arrangements that were in place to ensure that staff were provided with a list of currently prescribed medicines.

The management of medicines for one resident who had been discharged from hospital to the home was reviewed. The hospital discharge letter had been received and a copy had been forwarded to the resident's GP. The resident's personal medication records 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.

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. The manager was familiar with the type of incidents that should be reported.

The audit system in place helps staff to identify medicine related incidents. The manager discussed the arrangements for auditing and the consideration of how she was planning to delegate this to staff. The audit arrangements were discussed for residents who may receive respite care, should Covid restrictions ease in the coming months.

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.

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 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.

6.0 Conclusion

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

No new areas for improvement were identified. We can conclude overall that the residents were being administered their medicines as prescribed. Based on the inspection findings and discussions held, we are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the manager/management team.

We would like to thank the residents, relatives/representatives and staff for their assistance throughout the inspection.

7.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Mrs Andrea McComiskey, Manager, as part of the inspection process and can be found in the main body of the report.

	Regulations	Standards
Total number of Areas for Improvement	0	6*

*Areas for improvement carried forward for review at the next care inspection.

Quality Improvement Plan

Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011	
Area for improvement 1 **Ref**: Standard 6.6 **Stated:** Second time **To be completed by:** 19 February 2021	The registered person shall ensure that risk assessments for residents are reviewed on a regular basis or when any change occurs. Ref: 5.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 2 **Ref**: Standard 23 **Stated:** First time **To be completed by:** 31 March 2021	The registered person shall ensure that a system is developed to maintain staffs' compliance with mandatory training. Ref: 5.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 3 **Ref**: Standard 28.3 **Stated:** First time **To be completed by:** 19 February 2021	The registered person shall ensure that any defects reported are managed in a timely manner. Ref: 5.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 4 **Ref**: Standard 24.5 **Stated:** First time **To be completed by:** 31 March 2021	The registered person shall ensure that a system is developed to ensure all care staff receives an annual appraisal. Ref: 5.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 5 **Ref**: Standard 6.3 **Stated:** First time **To be completed by:** 31 March 2021	The registered person shall ensure that all residents' care records are signed and dated by the person creating the record for use. Any record no longer valid should be discontinued; signed, dated and archived. Ref: 5.1

	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Area for improvement 6 **Ref**: Standard 20.10 **Stated:** First time **To be completed by:** 30 April 2021	The registered person shall ensure that an effective care record audit tool is developed and implemented to monitor record keeping practices in the home. Ref: 5.1
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews