Inspection Report

18 November 2021

Limetree

Type of service: Residential Care Home
Address: 133 Comber Road, Dundonald, BT16 2BT
Telephone number: 028 9048 0252

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: Limetree **Responsible Individual:** Mrs Gertrude Alexandra Priscilla (Sandra) Nixon, registration pending	**Registered Manager:** Mr Simon Swail, registration pending
Person in charge at the time of inspection: Mrs Sandra Nixon	**Number of registered places:** 44 This number includes: • a maximum of four residents in the RC - PH category of care • a maximum of 32 residents in RC-DE category of care
Categories of care: Residential Care (RC): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 38
Brief description of the accommodation/how the service operates: This is a residential care home registered to provide residential care for up to 44 residents.	

2.0 Inspection summary

An unannounced inspection took place on 18 November 2021 from 10.20am to 1.40pm. The inspection was carried out by a pharmacist inspector and focused on medicines management within the home.

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

Review of medicines management found that residents were administered their medicines as prescribed. There were arrangements for auditing medicines and medicine records were well maintained. 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, 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. We also spoke to 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

We met with one senior carer, the deputy manager and the 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, no feedback had been received by RQIA.

5.0 The inspection

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

Areas for improvement from the last care inspection (16 February 2021)		
Action required to ensure compliance with the DHSSPS Residential Care Homes Minimum Standards, August 2011		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 25.8	The registered person shall ensure the following:	**Carried forward to the next care**

Stated: Second time	• A signing in sheet is kept for each staff meeting. • A system is put in place to evidence that minutes are shared with those staff who did not attend.	**inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care 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 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 and 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 verified and signed the personal medication records when they were written and updated to provide a check that they were accurate. It was evident that staff used these records as part of the administration of medicines process.

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 and self-administration.

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.

The management of medicines prescribed on a “when required” basis for the management of distressed reactions was reviewed for one resident. A care plan directing the use of the medicine was available. 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 record and records of administration were accurately maintained. The reason for and outcome of administration were recorded.

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 for two residents. Staff were familiar with both residents’ recommendations. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Care plans were in place when residents required insulin to manage their diabetes. There was sufficient detail in the care plan to direct staff if the resident’s blood sugar was too low. Staff were reminded that the date of opening should be recorded on insulin pens to facilitate audit and disposal at expiry.

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 residents’ 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.

Satisfactory systems were in place to ensure that medicines requiring cold storage were stored at the correct temperature.

Appropriate arrangements were in place for the 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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. The sample reviewed had been fully and accurately completed. A small number of missed signatures were brought to the attention of the deputy manager for ongoing close monitoring. The records were filed once completed and were readily available for audit/review.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. Robust arrangements were in place for the management of controlled drugs.

The deputy manager completed monthly audits on the management and administration of medicines. Findings were discussed with staff and records maintained.

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 management of medicines for four residents who had been recently admitted to the home was reviewed. The medicines prescribed had been confirmed with the GP practice and/or hospital discharge letters had been received and a copy had been forwarded to the resident's GP. Personal medication records had been accurately written. 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 any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

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 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 in order to prevent a recurrence.

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.

The audits completed at the inspection indicated that the medicines were being administered as prescribed.

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

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.

Records of staff training and competency assessment in relation to medicines management were available for inspection.

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 with respect to the management of medicines.

Based on the inspection findings and discussions held, RQIA was assured 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 with respect to the management of medicines. No new areas for improvement were identified with regards to medicines management. One area for improvement identified at the last care inspection was carried forward for review at the next care inspection.

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

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005 and The Residential Care Homes Minimum Standards (2011).

	Regulations	Standards
Total number of Areas for Improvement	0	1*

* the total number of areas for improvement includes one which is carried forward for review at the next inspection.

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

Quality Improvement Plan

Action required to ensure compliance with the Residential Care Homes Minimum Standards (2011)

Area for improvement 1 **Ref**: Standard 25.8 **Stated:** Second time **To be completed by:** 30 June 2020	The registered person shall ensure the following: • A signing in sheet is kept for each staff meeting. • A system is put in place to evidence that minutes are shared with those staff who did not attend. **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.** Ref: 5.1

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