The Regulation and Quality Improvement Authority

Inspection Report

15 December 2021

Oakridge Residential Unit

Type of Service: Residential Care Home
Address: 14 Magheraknock Road, Ballynahinch BT24 8TJ
Tel No: 028 9756 5322

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: Spa Nursing Homes Ltd **Responsible Individual:** Mr Christopher Philip Arnold	**Registered Manager:** Mrs Kelly Kilpatrick **Date registered:** 23 January 2020
Person in charge at the time of inspection: Mrs Kelly Kilpatrick	**Number of registered places:** 10
Categories of care: Residential Care (RC) RC-DE	**Number of residents accommodated in the residential care home on the day of this inspection:** 9
Brief description of the accommodation/how the service operates: This home is a registered residential care home which provides social care for up to 10 people with dementia. There is also a registered nursing home under the same roof. The residential care home is located on the ground floor with access to an enclosed courtyard.	

2.0 Inspection summary

An unannounced inspection took place on 15 December 2021 between 9.40am and 12.30pm. This inspection was conducted by a pharmacist inspector and 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.

Review of medicines management found that residents were being administered their medicines as prescribed. There were robust 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. There was one area for improvement identified relating to care planning.

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 a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines were reviewed.

4.0 What people told us about the service

The inspector met with the three members of staff and the manager.

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.

The staff members spoken with expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs. They said that the manager was very supportive of staff and 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 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.

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 inspection on 3 November 2021		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 20 (1) (a) **Stated:** First time	The Registered Persons must ensure that a competent and capable person is rostered to take charge of the home at all times.	**Carried forward to the next inspection**
	Action taken as confirmed during the Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Area for Improvement 2 **Ref:** Regulation 16 (1) **Stated:** First time	The Registered Persons shall ensure that all residents have comprehensive care plans in place detailing the individual care required.	**Carried forward to the next inspection**
	Action taken as confirmed during the Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Area for Improvement 3 **Ref:** Regulation 14 (1) (c) **Stated:** First time	The Registered Persons shall ensure that the space under the stairwell is monitored to ensure it is not used as a storage area. Records must be maintained to evidence monitoring of this area.	**Carried forward to the next inspection**
	Action taken as confirmed during the Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is 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 medical 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 review 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 were accurate.

Copies of residents' prescriptions and 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.

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 for three residents was reviewed. 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 of the medicines were clearly recorded on the personal medication records and records of administration were maintained. The reason for and outcome of administration were recorded in the daily progress notes. However, for each of the three residents, care plans directing the use of the medicines as part of a behavioural management strategy were not available. Whenever a resident is prescribed a medicine for administration on a "when required" basis as part of a behavioural management strategy, this should be reflected in a care plan; an area for improvement was identified.

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. The records belonging to two residents who were prescribed medicines for the management of pain were

reviewed. Care plans directing the use of the pain management medicines were available and pain management audit tools were in use.

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. 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 area was observed to be securely locked to prevent any unauthorised access. It was 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.

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

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 when medicines are administered to a resident. A sample of these records was reviewed and were found to have been completed to the required standard. 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 are recorded in a controlled drug record book. Robust arrangements were in place for the management of controlled drugs.

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.

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 was reviewed for one resident who had been admitted to this home. The medicines prescribed had been confirmed with the resident's GP. The resident's personal medication record had been accurately written and signed by two members of staff. 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 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 we completed at the inspection indicated that medicines had been 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 use.

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 in relation to the management of medicines.

Based on the inspection findings and discussions held, RQIA was satisfied that this service is providing safe and effective care with respect to the management of medicines and is being well led by the manager. Whilst one new area for improvement was identified, RQIA was assured that the residents were being administered their medicines as prescribed by their GP.

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 (2021).

	Regulations	Standards
Total number of Areas for Improvement	3*	1

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Kelly Kilpatrick, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 20 (1) (a) **Stated:** First time **To be completed by:** 3 November 2021	The Registered Persons must ensure that a competent and capable person is rostered to take charge of the home at all times. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Area for improvement 2 **Ref:** Regulation 16 (1) **Stated:** First time **To be completed by:** 3 November 2021	The Registered Persons shall ensure that all residents have comprehensive care plans in place detailing the individual care required. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Area for improvement 3 **Ref:** Regulation 14 (1) (c) **Stated:** First time **To be completed by:** 3 November 2021	The Registered Persons shall ensure that the space under the stairwell is monitored to ensure it is not used as a storage area. Records must be maintained to evidence monitoring of this area. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1

Action required to ensure compliance with Residential Care Homes Minimum Standards (2021)	
Area for improvement 1 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 14 January 2022	The Registered Person shall ensure that whenever a resident is prescribed a medicine for administration on a “when required” basis as part of a behavioural management strategy, this is reflected in a care plan. Ref: 6.2.1
	Response by registered person detailing the actions taken: The Registered Manager has ensured all residents who are prescribed a 'when required' medication as part of the behavioural strategy has a care plan to reflect this need.

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

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