The Regulation and Quality Improvement Authority

# Inspection Report

## 26 April 2021

# Palmerston

Type of Service: Residential Care Home
Address: 9-17 Palmerston Road, Belfast, BT4 1QA
Tel No: 028 9065 6166

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:**<br>Abbeyfield and Wesley Housing Association<br><br>**Responsible Individual:**<br>Mrs Geraldine Gilpin | **Registered Manager:**<br>Mr Paul Johnston<br><br>**Date registered:**<br>18 October 2019 |
| **Person in charge at the time of inspection:**<br>Mr Paul Johnston | **Number of registered places:**<br>39<br><br>Maximum number of twenty six residents in Category RC-DE. Maximum of 2 residents in Category RC-SI. |
| **Categories of care:**<br>Residential Care (RC):<br>I - Old age not falling within any other category<br>DE - Dementia<br>SI - Sensory impairment<br>PH(E) - Physical disability other than sensory impairment - over 65 years | **Number of residents accommodated in the residential care home on the day of this inspection:**<br>34 |
| **Brief description of the accommodation/how the service operates:**<br>This is a residential care home which is registered to provide care for up to 39 residents. | |

## 2.0 Inspection summary

An unannounced inspection took place on 26 April 2021, from 9.40am to 1.50pm. The inspection was completed by a pharmacist inspector.

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.

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 in relation to the management of medicines.

## 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 the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection, the inspector:

- 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 drug records
- care plans related to medicines management
- governance and audit
- staff training and competency
- medicine storage temperatures
- RQIA registration certificate

## 4.0 What people told us about the service

Staff were warm and friendly and it was evident from their interactions that they knew the residents well. They were wearing face masks and other personal protective equipment (PPE) as needed.

Staff spoken to 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 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. The respondent stated that they were very satisfied with all aspects of care.

## 5.0 The inspection

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

The last inspection was undertaken on 17 November 2020 by a care inspector; no areas for improvement were identified.

| **Areas for improvement from the last medicines management inspection on 17 April 2018** | | |
|---|---|---|
| **Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)** | | **Validation of compliance** |
| **Area for Improvement 1**<br><br>**Ref:** Standard 31<br><br>**Stated:** First time | The registered person shall ensure that all additions to personal medication records and medication administration records are verified and signed by two members of staff. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Additions to personal medication records and medication administration records were generally verified and signed by two members of staff. | |
| **Area for Improvement 2**<br><br>**Ref:** Standard 30<br><br>**Stated:** First time | The registered person shall ensure that procedures are reviewed to ensure that when a medicine is discontinued it is removed from stock. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>Staff confirmed that procedures had been reviewed to ensure that when a medicine is discontinued it is removed from stock. There were no discontinued medicines in the medicine trolleys. | |

## 5.2 Inspection outcome

### 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 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.

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 regarding 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. Records of administration were clearly recorded. The reason for and outcome of administration were 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.

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. A speech and language assessment report and care plan was in place. Records of prescribing did not always include the recommended consistency level; this was discussed with the manager who gave an assurance that the matter would be rectified without delay. Records of administration that included the recommended consistency level were maintained.

### 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 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.

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 on pre-printed medicine administration records (MARs) or occasionally handwritten MARs, 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. Several minor discrepancies were discussed. 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 a controlled drug record book, which was appropriately maintained.

Management audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on most medicines so that they could be easily audited; this is good practice. Several medicines did not have the date of opening recorded to facilitate auditing; this was drawn to the attention of the manager.

The audits completed during this inspection showed that medicines had largely been given as prescribed. A couple of small discrepancies were drawn to the attention of the manager for close monitoring.

Whenever a resident had their medicines administered in food and drinks to assist administration, a care plan was in place. The prescriber had provided written authorisation for this arrangement.

### 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 two residents who had recently been admitted to this home were reviewed. Written confirmation of their medicines had been obtained. The residents' personal medication records and MARs had been accurately maintained. The medicines had been 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 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.

### 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. Records of staff training 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 in relation to the management of medicines.

The outcome of this inspection concluded that the areas for improvement identified at the last medicines management inspection had been addressed. No new areas for improvement were identified.

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 can conclude that overall the residents were being administered their medicines as prescribed.

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

## 7.0 Quality Improvement Plan/Areas for Improvement

| | 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 Mr Paul Johnston, Manager, as part of the inspection process and can be found in the main body of the report.

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