Follow Up Inspection Report
26 January 2021

Redlands

Type of Home: Residential Care Home
Address: 20 Adelaide Park, Belfast, BT9 6FX
Tel No: 028 9066 1526
Inspector: Judith Taylor

It should be noted that 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 the course of this inspection. The findings contained within this report do not exempt the service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a residential care home which is registered to provide care for up to 17 residents.

3.0 Service details

Organisation/Registered Provider: Whiteabbey Proprietors Ltd **Responsible Individual:** Mr Mark John Uprichard	**Registered Manager and date registered:** Ms Irene Caroline Best
Person in charge at the time of inspection: Ms Irene Caroline Best	**Number of registered places:** 17
Categories of care: Residential Care (RC): I – old age not falling within any other category DE – dementia	**Total number of residents in the residential care home on the day of this inspection:** 13

4.0 Inspection summary

This inspection was undertaken by a pharmacist inspector on 25 January 2021 between 10.55 and 13.55.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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).

The last inspection on 3 August 2020 indicated that robust arrangements were not in place for medicines management. This inspection focused on medicines management and sought to assess progress with the issues raised at the last inspection.

There was evidence that the medicine related areas identified for improvement had been addressed in a satisfactory manner. Management had reviewed and developed the systems in place to ensure the safe management of medicines and staff had received supervision. The improvements which had been made were acknowledged.

The following areas were examined during the inspection:

- management of medicine changes
- the standard of record keeping including care plans
- auditing arrangements for medicines

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and resident's experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

The area for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Irene Best, 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.

4.2 Action/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 3 August 2020. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Before the inspection a range of information relevant to the service was reviewed. This included the following:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last inspection

During the inspection the inspector met with care assistants and the manager.

A sample of the following records was examined and/or during the inspection:

- medicines received
- personal medication records
- medicine administration
- medicine audits
- care plans related to medicines
- training records
- medicines storage temperatures

Areas for improvements identified at the last medicines management inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the last care inspection (5 March 2020) and last medicines management inspection (3 August 2020)

There were no areas for improvement identified as a result of the last care inspection (5 March 2020).

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** Second time	The registered person shall ensure that there are safe systems in place for managing medication changes.	**Met**
	Action taken as confirmed during the inspection: Examination of medicine records indicated that medicines changes had been managed appropriately.	
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** Second time	The registered person shall ensure that personal medication records are up to date and the areas identified for improvement addressed.	**Met**
	Action taken as confirmed during the inspection: The personal medication records had been rewritten after the last inspection. These were well maintained and included the relevant information.	
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** Second time	The registered person shall implement a robust auditing system to ensure that any shortfalls in relation to medicines management are identified and improvements are sustained.	**Met**
	Action taken as confirmed during the inspection: The auditing systems had been reviewed and revised. There was evidence that a range of audits were completed daily, weekly and monthly. Areas for improvement were	

	identified and monitored by the manager and designated staff.	
Area for improvement 4 **Ref:** Regulation 13(4) **Stated:** First time	The registered person shall ensure that records of all medicines administered are fully and accurately maintained; this should include a review of the record keeping for topical medicines.	**Met**
	Action taken as confirmed during the inspection: There was evidence of improvement in the completion of records for administered medicines, including topical medicines. These records were included in the weekly audits.	
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 8 **Stated:** Second time	The registered person shall review the management of distressed reactions to ensure that care plans are in place. The reason for and outcome of each administration should be recorded.	**Met**
	Action taken as confirmed during the inspection: A new system had been developed and included a written protocol on the management of distressed reactions. Details were also included in the resident's care plan. Although there had been no recent use, there was a system in place to enable staff to record the reason for and outcome of any administration.	
Area for improvement 2 **Ref**: Standard 6 **Stated:** First time	The registered person shall ensure that the resident's pain management is referenced in the resident's care plan.	**Met**
	Action taken as confirmed during the inspection: Examination of five residents' records indicated that pain management was clearly referenced.	

Area for improvement 3 **Ref**: Standard 31 **Stated:** First time	The registered person shall ensure the prescribed consistency level of thickened fluids is clearly recorded on all medicine related records.	**Met**
	Action taken as confirmed during the inspection: Review of three residents' records indicated that the prescribed consistency level of thickened fluid was recorded. The administration records indicated that the prescribed consistency level was being administered.	
Area for improvement 4 **Ref**: Standard 33 **Stated:** First time	The registered person shall review the management of self-administered medicines and ensure that the relevant records are maintained.	**No longer applicable**
	Action taken as confirmed during the inspection: There were no residents who were deemed competent to self-administer their medicines. The manager advised that all medicines were administered by staff.	
Area for improvement 5 **Ref**: Standard 32 **Stated:** First time	The registered person shall make the necessary arrangements to ensure staff do not share or re-use medicines.	**Met**
	Action taken as confirmed during the inspection: There was no evidence that any medicines were shared or re-used. Any discontinued medicines were returned to the community pharmacy for disposal.	
Area for improvement 6 **Ref**: Standard 30 **Stated:** First time	The registered person shall use the QIP as part of their ongoing audit process to drive the necessary improvement in medicines management.	**Met**
	Action taken as confirmed during the inspection: The audit process had been developed to include the areas identified at the last inspection.	

Area for improvement 7 **Ref**: Standard 30 **Stated:** First time	The registered person shall ensure that staff are provided with further training in medicines management and ensure this covers the areas identified at the inspection.	**Met**
	Action taken as confirmed during the inspection: The inspection outcomes had been shared with designated staff at a team meeting and training provided on the improvements required. Formal training from the community pharmacist had been scheduled; however, had to be postponed and a new date is to be arranged.	

6.2 Inspection findings

Management of medicines changes

There had been several new medicines prescribed and changes in medicines doses. We selected a number of these and noted they had been managed appropriately, with two staff involved in writing the personal medication records to ensure accuracy. The audit trails on these medicines indicated they had been administered as prescribed. Details of changes were also recorded in the resident's daily notes.

The standard of record keeping including care plans

We identified a good improvement in the completion of medicine records and care plans. Personal medication records had been rewritten and signed; there was a system in place to ensure correlation with these and printed medication administration records. The medicine records specific for topical medicines had been updated. Whilst we acknowledged the improvements made, the records included several amended entries and overwriting in relation to recording errors. Original entries must not be amended. Any errors should be recorded appropriately without obscuring the original entry, and the entire entry should be rewritten. This was identified as an area for improvement.

In relation to care plans, we reviewed the management of distressed reactions, pain management and swallowing difficulty. These had also been reviewed and updated and were signed by staff to indicate that they had read and understood them. In addition to the care plans, a separate protocol was put in place for medicines administered on a "when required" basis; this protocol included areas for staff to record the reason for and outcome of any administration.

Auditing arrangements for medicines

The manager provided details of the action taken regarding medicines management since the last inspection. Staff attended a training meeting on 24 August 2020, to discuss the inspection findings with particular emphasis on record keeping, stock control and the improvements that must be made. The manager also provided assurances that staff were aware that discontinued medicines must be returned to the community pharmacy for disposal and must not be

administered to any other resident. Formal medicines management training had been planned, but had to be postponed. Online training is scheduled.

As part of the improvements, the auditing process had been developed to include effective systems to monitor medicines management. This occurred through daily, weekly and monthly audits by staff and the manager, and follow up of any deficits identified.

Areas for improvement

One area for improvement was identified in relation to the management of recording errors.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

The area for improvement identified during this inspection is detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Irene Best, 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.

7.1 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).

7.2 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 Web Portal for assessment by the inspector.

Quality Improvement Plan

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 31 **Stated:** First time	The registered person shall monitor the completion of medicine records to ensure that any recording errors are managed appropriately. Ref: 6.2
To be completed by: Immediately and ongoing	**Response by registered person detailing the actions taken:** Any errors are now recorded appropriately without obscuring the orginal entry. Errors are corrected by staff drawing a thin line through the error and rewriting the entry. This procedure is checked through daily and weekly audits.

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

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

Assurance, Challenge and Improvement in Health and Social Care