Inspection Report
3 August 2020

Redlands

Type of Service: Residential Care Home
Address: 20 Adelaide Park, Belfast, BT9 6FX
Tel: 028 9066 1526
Inspector: Judith Taylor

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 this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

Redlands is registered to provide residential care for up to 17 residents with categories of care as stated in the certificate of registration.

2.0 Service details

Organisation/Registered Provider: Whiteabbey Proprietors Ltd **Responsible Individual:** Mr Mark John Uprichard	**Registered Manager:** Mrs Irene Best
Person in charge at the time of inspection: Mrs Irene Best	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) I – Old age not falling within any other category DE – Dementia	**Number of registered places:** 17

3.0 Inspection

This inspection was completed by a pharmacist inspector on 3 August 2020 from 10.55 to 16.20.

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.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

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

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	4*	7*

The outcome of this inspection confirmed that the areas identified for improvement at the last inspection had not been fully addressed and have been stated for a second time.

*The total number of areas for improvement includes three which have been stated for a second time under the Regulations and one which has been stated for a second time under the Standards.

5.0 What has this service done to meet any areas for improvement made at the last medicines management inspection on 31 August 2017 and last care inspection on 5 March 2020?

No areas for improvement were identified at the last care inspection on 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:** First time	The registered person shall ensure that there are safe systems in place for managing medication changes.	**Not met**
	Action taken as confirmed during the inspection: A review of several residents' records indicated that records had not been updated to reflect the change. **This area for improvement is stated for a second time.**	
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered person shall ensure that personal medication records are up to date and the areas identified for improvement addressed.	**Not met**
	Action taken as confirmed during the inspection: We identified a number of incomplete and/or inaccurate personal medication records. **This area for improvement is stated for a second time.**	
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First 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.	**Not met**
	Action taken as confirmed during the inspection: The inspection findings indicate that the current audit process is not robust; it is not effective in identifying issues and areas for improvement. **This area for improvement is stated for a second time.**	

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		Validation of compliance
Area for improvement 1 **Ref:** Standard 8 **Stated:** First time	The registered person shall review that management of distressed reactions to ensure that care plans are in place. The reason for and outcome of each administration should be recorded.	**Partially met**
	Action taken as confirmed during the inspection: These medicines were rarely administered and the reason for use and outcome were recorded. However, a care plan was not in place. **This area for improvement is stated for second time.**	

6.0 What people told us about this service

Residents were observed to be relaxing in the lounge or in their bedrooms watching television. One resident had a relative visiting. Staff were warm and friendly and it was evident from their interactions, that they knew the residents well.

We met with the manager and one other member of staff. 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 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

7.0 Medicines Management

7.1 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 residents' needs will change and therefore their medicines should be regularly monitored and reviewed. This may be done by the GP, medical consultant or the pharmacist.

Residents in the home were registered with a local 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 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. We identified that these records were not up to date with the most recent prescription and some were incomplete. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff did not use these records as part of the administration of medicines process. This was discussed in detail with registered manager and staff. This issue had been raised at the last medicines management inspection and two areas for improvement have been stated for a second time.

Copies of residents' prescriptions are retained in the home and staff confirmed that they are used to check that all prescribed medicines are available for administration. We acknowledged that overall medicines were available and being administered accurately. It was reiterated that staff should use these prescriptions to cross reference with the resident's personal medication record to ensure accuracy.

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, and modified diets e.g. the use of thickening agents. We reviewed medicine related care plans for five residents. Whilst most of these were satisfactory, further detail should be recorded in relation to distressed reactions and pain management; this was discussed with management and staff. One area for improvement has been stated for a second time and one new area for improvement in relation to care planning for pain has been made.

Some resident may require fluids to be thickened to different consistencies to aid swallowing. In relation to the management of thickening agents, we evidenced that care plans were in place, however, the consistency level was not routinely recorded on the personal medication records or records of administration. This is necessary to ensure the correct consistency is safely administered to each resident. An area for improvement was identified.

Residents may wish to look after their own medicines in relation to storage and administration. This is encouraged where the resident is deemed capable to do this, following a risk assessment. We discussed the current arrangements in place self-administration of medicines. A detailed protocol should be developed and implemented. Staff should record the date and quantity of the medicine issued to the resident and should use this record to monitor compliance and review ongoing competence. Self-administration should also be referenced in a care plan. An area for improvement was identified.

7.2 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.

With the exception of one medicine, the records inspected showed that medicines were available for administration when residents required them (see also Section 7.3). 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. Advice was given in relation to Schedule 4 (Part 1) controlled drugs regarding storage and audit.

We reviewed the disposal arrangements for medicines. Discontinued medicines were returned to the community pharmacy for disposal and records maintained. However, we identified a small number of medicines e.g. analgesics and laxatives stored on the medicine trolley where the medicine label had been fully or partially removed and overwritten with a different resident's name. There was stock of these residents' medicines available. Residents must only be administered medicines from their own supply and there must be no sharing or re-using of medicines. An area for improvement was identified.

7.3 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 their prescribed medicines at the right time.

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 were reviewed which found that they had not been fully and accurately completed. This included records regarding topical medicines. This means that medicines may have been administered without a record being made. Several did not correlate with the corresponding personal medication records. Both of these records must match to ensure that medicines are being administered to residents as prescribed. A system should be in place to ensure these are checked at each change of the medicine cycle. Two areas for improvement were made.

The date of opening was usually recorded on medicines so that they can be easily audited. This is good practice.

We reviewed the administration of two pain relieving patches. These were prescribed on the resident's personal medication record. However, there had been no recent administration, no stock was held and had not been ordered for some time. Staff were unable to confirm if the patch was currently prescribed. The registered manager was requested to investigate this observation and provide a response by 5 August 2020. A satisfactory response was received on 4 August 2020; these medicines had been discontinued; however, the records had not been updated to reflect this change.

As part of ensuring that medicines are administered correctly, a monthly audit is completed by management/staff. We were provided with samples of these audits. (See also Section 7.5.)

7.4 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.

There had been no recent admissions to the home. However, we discussed the admission process for residents new to the home or returning to the home after receiving hospital care. Staff advised that robust arrangements were in place to ensure that they were provided with a list of medicines from the hospital and this was shared with the resident's GP and the community pharmacist. The need for the personal medication records to be accurately written/rewritten was reiterated.

7.5 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 that 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.

There have been no medicine related incidents reported to RQIA since 2013. Following discussion it was evident that staff knew the types of incidents that should be reported to RQIA. However, as detailed above there are shortfalls in medicines management and the audit system is not effective in identifying these; therefore, medicine related incidents may not be identified appropriately, analysed and reported.

The need for a robust audit system which covers all aspects of medicines is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff.

As we identified the ongoing non-administration of one medicine (eye preparation), this must be reported to RQIA. A notification regarding this incident and corrective action taken was received by RQIA on 5 August 2020.

The audits we completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. A review of the monthly management audits indicated that the issues raised at this inspection were not being identified and needs to be expanded. The area for improvement was stated for a second time.

7.6 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.

There was evidence that staff responsible for medicines management had received induction training and ongoing refresher training. Records showed that staff competency had been assessed following induction and annually thereafter. However, whilst this was acknowledged, the inspection findings indicate that further training is necessary to ensure that robust systems are in place for the safe management of medicines. An area for improvement has been made.

The areas for improvement made at the last medicines management inspection had not been fully met. It was recommended that the QIP from this inspection is shared with staff and used as part of the governance and audit processes to ensure the necessary improvement is made and sustained. An area for improvement has been made.

8.0 Evaluation of Inspection

This inspection sought to assess if the home was delivering safe, effective and compassionate care and if the service was well led.

The outcome of this inspection concluded that robust arrangements were not in place for all aspects of medicines management. Four areas for improvement identified at the last medicines management inspection have been stated for a second time and seven new areas for improvement have been identified as detailed in the report and QIP.

Whilst we identified areas for improvement, we can conclude that overall, with the exception of a small number of medicines, the residents were being administered their medicines as prescribed by their GP.

Following the inspection the findings were discussed with the Senior Pharmacist Inspector and with Mr Mark Uprichard, Responsible Individual. RQIA decided that a period of time would be given to implement the necessary improvements. A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained. Failure to implement and sustain the improvements may lead to enforcement.

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

9.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Irene Best, Registered Manager,

Mr Mark Uprichard, Responsible Individual, and one member of senior staff, 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.

9.1 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).

9.2 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 the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS)The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** Second time **To be completed by:** Immediate and ongoing	The registered person shall ensure that there are safe systems in place for managing medication changes. Ref: 5.0 & 7.1
	Response by registered person detailing the actions taken: Staff sign the incoming book to indicate they have updated the Kardex and MAR when residents receive new medication This is now audited weekly by Home manager
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** Second time **To be completed by:** Immediate and ongoing	The registered person shall ensure that personal medication records are up to date and the areas identified for improvement addressed. Ref: 5.0 & 7.1
	Response by registered person detailing the actions taken: Residents Kardex have been updated to reflect their current medication
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** Second time **To be completed by:** Immediate and ongoing	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. Ref: 5.0 & 7.5
	Response by registered person detailing the actions taken: The audit process has been reviewed
Area for improvement 4 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** Immediate and ongoing	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. Ref: 5.3
	Response by registered person detailing the actions taken: The manager has commenced weekly audits to ensure medication and topical medicines, are administered correctly and signed for.

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 **To be completed by:** Immediate and ongoing	The registered person shall review that management of distressed reactions to ensure that care plans are in place. The reason for and outcome of each administration should be recorded. Ref: 5.0 & 7.1
	Response by registered person detailing the actions taken: One resident is prescribed medication for distressed reaction the reason and outcome is recorded when administered in the medication file. The resident care plan has now been updated.
Area for improvement 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that the resident's pain management is referenced in the resident's care plan. Ref: 7.1
	Response by registered person detailing the actions taken: This has commenced and will be completed for all residents ASAP
Area for improvement 3 **Ref**: Standard 31 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure the prescribed consistency level of thickened fluids is clearly recorded on all medicine related records. Ref: 7.1
	Response by registered person detailing the actions taken: Kardex and MAR updated Staff sign to indicate consistency level when preparing fluids This is recorded on a separate sheet held in the staff office.
Area for improvement 4 **Ref**: Standard 33 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall review the management of self-administered medicines and ensure that the relevant records are maintained. Ref: 7.1
	Response by registered person detailing the actions taken: One resident at the time of the inspection self administered her medication. She has now asked staff to administer her medication, as she was finding it more difficult to manage.

Area for improvement 5 **Ref**: Standard 32 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall make the necessary arrangements to ensure staff do not share or re-use medicines. Ref: 7.2
	Response by registered person detailing the actions taken: The Home manager commenced audits weekly
Area for improvement 6 **Ref**: Standard 30 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall use the QIP as part of their ongoing audit process to drive the necessary improvement in medicines management. Ref: 7.5
	Response by registered person detailing the actions taken: This will be included in the audit process, and staff training
Area for improvement 7 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 31 August 2020	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. Ref: 7.6
	Response by registered person detailing the actions taken: Staff training was booked for 24/09/2020,but due to COVID-19 restrictions this has ben cancelled The manager will rearrange a suitable date and time with the homes pharmacist. The areas identified in the inspection has been shared with the pharacist.

Please ensure this document is completed in full and returned via the 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