The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Positive Futures Wheatfield Short Break Service

Provider: Positive Futures

Date of Inspection: 28 November 2024

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation:	Positive Futures
Responsible Individual:	Ms Agnes Lunney
Registered Manager:	Mrs Bernice Kelly
Service Profile: Positive Futures Wheatfield Short Breaks Service is a residential care home which provides short break health and social care for up to five residents.	

2.0 Inspection summary

An unannounced inspection took place on 28 November 2024, from 10.15am to 12.40pm. This was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management.

Review of medicines management found that mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care records were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. One area for improvement was identified in relation to monitoring medicine storage temperatures.

Whilst an area for improvement was identified, there was evidence that residents were being administered their medicines as prescribed.

Residents were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the residents well.

Details of the inspection findings and the new area for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

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

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, 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 registration information and any other written or verbal information received from residents, relatives, staff or the commissioning trust.

Throughout the inspection the RQIA inspector will seek to speak with residents, their relatives or visitors and staff to obtain their opinions on the quality of the care and support, their experiences of living, visiting or working in this home.

3.2 What people told us about the service and their quality of life

RQIA did not receive any completed questionnaires or responses to the staff survey following the inspection.

Staff on duty 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. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each resident liked to take their medicines. They stated medication administration was tailored to respect each individual's preferences, needs and timing requirements.

3.3 Inspection findings

3.3.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents bring their own medicines into the home with them at the beginning of their stay and any unused medicines are returned at the end of their stay. Following discussions with staff, it was evident that when applicable, other healthcare professionals were contacted in response to residents' needs and should medicines be prescribed during their stay arrangements were in place to ensure these were obtained in a timely manner.

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 or hospital appointments.

Since this is a short break respite service, residents were registered with their own GP and a personal medication record was kept on file for each resident. Arrangements were in place for the safe management of medicines for each short stay. Personal medication records/entries were signed by two members of staff. Robust procedures were in place to manage any changes during each short stay.

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, epilepsy etc.

The management of medicines prescribed on a "when required" basis for the management of pain and for seizures was reviewed. Directions were recorded on personal medication records and in the care plan and where relevant, epilepsy management plans were in place.

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

3.3.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

As part of the admission process staff must make the necessary arrangements to ensure that the resident's medicines are available for administration as prescribed during their stay in the home. It is important that medicines are stored safely and securely so that there is no unauthorised access and that appropriate arrangements are made to return medicines to carers at the end of the stay.

Systems were in place to ensure that sufficient medicines were supplied for each stay and any medicines remaining at the end of the stay were returned. Outside of this arrangement, arrangements were in place for the safe disposal of medicines if necessary.

The medicine 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. Arrangements were in place for any medicines that may require cold storage and for the storage of controlled drugs. The temperature of the medicines storage areas should be monitored and recorded daily to ensure that medicines are stored at or below 25◦C. An area for improvement was identified.

3.3.3 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.

A sample of the medicines administration records was reviewed. Records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

There were satisfactory arrangements in place for the management of controlled drugs.

Staff audited medicine administration at the end of each stay to check that medicines had been administered as prescribed.

3.3.4 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 admission process for new and returning residents was discussed. Robust arrangements were in place to check current medicine regimes with the resident's representative and when necessary, to obtain a list of current medicines from the resident's GP.

3.3.5 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. A robust audit system will help 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 the learning shared with staff in order to prevent a recurrence.

3.3.6 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 they staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Training included medicines management, epilepsy and the management of seizures, anaphylaxis management and dysphagia. Medicines management policies and procedures were in place.

4.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	1

The new area for improvement and details of the Quality Improvement Plan were discussed with Mrs Bernice Kelly, Registered Manager, as part of the inspection process. The timescale for completion commences from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022	
Area for improvement 1 **Ref:** Standard 32 **Stated:** First time **To be completed by:** 2 December 2024	The registered person shall ensure that the temperature of the medicine storage areas is monitored and recorded daily. Ref: 3.3.2
	Response by registered person detailing the actions taken: Complete - 2 December 2024: Digital thermometers purchased were installed on the walls of both medicines storage rooms. Temperature readings are being recorded.

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

The Regulation and Quality Improvement Authority

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