Inspection Report

21 August 2023

Tennent Street Care Home

Type of service: Residential Care
Address: Hampton Suite,
1 Tennent Street,
Belfast,
BT13 3GD
Telephone number: 028 9031 2318

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: Beaumont Care Homes Ltd **Responsible Individual** Mrs Ruth Burrows	**Registered Manager:** Mr Mauro J Magbitang Jr (Acting)
Person in charge at the time of inspection: Mr Mauro J Magbitang Jr	**Number of registered places:** 16 This number includes a maximum of eight persons in category of care RC-MP.
Categories of care: Residential Care (RC): I – old age not falling within any other category DE – dementia MP – mental disorder excluding learning disability or dementia 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:** 16
Brief description of the accommodation/how the service operates: Tennent Street Care Home is a residential care home which is registered to provide health and social care for up to 16 residents. Residents' bedrooms, a communal lounge and dining room are located on the ground floor Hampton Suite. There is a nursing home on the same site and the manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 21 August 2023, from 10.15am to 2.30pm. This was completed by a pharmacist inspector and focused on medicines management within the home. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

Following discussion with the aligned care inspector, it was agreed that the area for improvement identified at the last care inspection would be followed up at the next care inspection.

RQIA received information on 4 August 2023 which raised concerns in relation to the management of medicines in Tennent Street Care Home. In response to this information RQIA decided to undertake an inspection.

The information received by RQIA was discussed with the newly appointed manager who provided details of recent changes which had been implemented in the home to ensure that safe systems were in place for the management of medicines. Review of medicines management found that medicine records and medicine related care plans were maintained to a satisfactory standard. The audit process to ensure residents were administered their medicines as prescribed had recently been reviewed and improved. The area for improvement identified at the last medicines management inspection in relation to distressed reactions had been addressed. One new area for improvement in relation to the disposal of medicines was identified.

Based on the inspection findings and discussions held RQIA were assured that satisfactory systems were in place for the management of medicines. However, we will continue to closely monitor.

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

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. The inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke to staff and management about how they plan, monitor and deliver the management of medicines. Residents views were also obtained.

4.0 What people told us about the service

The inspector met briefly with three residents. All residents were complimentary of the care received in Tennent Street Care Home. Comments made included, "the food is great" and "we are well looked after". In relation to medicines management, residents spoken with stated they were administered their medicines by the staff in a dignified manner.

The inspector also met with care staff and the manager. The manager informed the inspector that the home currently employs agency staff to cover a large number of shifts in the home. He also stated that the quantity and frequency of medicine audits had been increased recently to ensure all residents are administered their medicines as prescribed.

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, 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 the last inspection?

Areas for improvement from the last medicines management inspection on 31 August 2022		
Action required to ensure compliance with The Residential Care Homes Minimum Standards 2022		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 6 **Stated:** First time	The registered person shall review the management of distressed reactions to ensure that: - a detailed care plan is in place to direct care - the reason for and outcome of administering the medicines is recorded.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was assessed as met. See Section 5.2.1.	

Areas for improvement from the last care inspection on 2 November 2022		
Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that all notifiable events which occur in the residential care home are reported appropriately to RQIA.	**Carried forward to the next inspection**
	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 practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times the residents' needs may 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 reviews 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 state that they were accurate.

Copies of residents' prescriptions 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 distressed reactions was reviewed for two residents. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain or infection. Review of the medicine administration records identified these medicines were administered infrequently. Staff advised that the reason for and outcome of administration were recorded.

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. Care plans were in place and reviewed regularly.

The management of insulin was reviewed. A care plan was in place for one resident who required insulin to manage their diabetes. There was sufficient detail in the care plan to direct staff if the resident's blood sugar was too low. Insulin was administered by the district nurse; records of the administration were available for review.

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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Medicines for disposal must be stored securely to prevent unauthorised access and returned to the community pharmacy in a timely manner. Records of disposal/transfer to the community pharmacy should be accurately maintained and available for inspection. This is necessary to evidence that medicines have been appropriately disposed of. Records of medicines returned to the community pharmacy were maintained in the medicine disposal book. However, it was identified that a number of medicines recently recorded in the disposal book had not been signed as transferred to the community pharmacy. An area for improvement was identified. As the identified discontinued medicines were not available in the home, the manager was requested to complete an investigation and submit the findings to RQIA. The initial findings were submitted to RQIA on 22 August 2023.

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.

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

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 should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

The audit process for medicines management had recently been reviewed. Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out including daily running stock balances to monitor administration.
The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

The audits completed by the inspector identified the medicines were being administered as prescribed.

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.

There had been no recent admissions to the home. However, the admission process for new residents or residents returning from hospital was reviewed. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the resident's medicines and this was shared with the community pharmacist.

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. 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 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 they are supported. Policies and procedures should be up to date and readily available for staff.

As stated in Section 4.0, the manager advised that agency staff were employed to cover a large number of shifts in the home. There were records in place to show that agency staff responsible for medicines management had received a structured induction which included medicines management. The manager also advised that supervisions were planned for all agency staff in relation to the medicines management audits to be completed during shifts.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with The Residential Care Homes Minimum Standards, 2022.

	Regulations	Standards
Total number of Areas for Improvement	1*	1*

* The total number of areas for improvement includes one which is carried forward for review at the next inspection.

The area for improvement and details of the Quality Improvement Plan were discussed with Mr Mauro J Magbitang Jr, 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 Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** With immediate effect (2 November 2022)	The registered person shall ensure that all notifiable events which occur in the residential care home are reported appropriately to RQIA. **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 The Residential Care Homes Minimum Standards 2022	
Area for improvement 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** With immediate effect (21 August 2023)	The registered person shall ensure that medicines awaiting disposal are stored securely, disposed of in a timely manner and records of disposal and transfer are accurately maintained. Ref: 5.2.2 **Response by registered person detailing the actions taken:** Medicine Disposal Storage has been reviewed and a new system put in place. A new lockable storage cabinet for the medications awaiting disposal has been purchased. Staff meetings and supervision will be undertaken in relation to medication administration,disposal and recording with all senior care staff involved in medication administration. The Home Manager will monitor this area of improvement via completion of the Monthly medication audit. Compliance with this area of improvement will be monitored through the monthly Regulation 29 Report.

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The Regulation and Quality Improvement Authority

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