Inspection Report
9 September 2020

Twisel Lodge

Type of Service: Residential Care Home
Address: 19a Church Avenue, Holywood, BT18 9BJ
Tel No: 028 9042 8458
Inspector: Rachel Lloyd

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

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

2.0 Service details

Organisation/Registered Provider: The Cedar Foundation **Responsible Individual:** Mrs Margaret Cameron	**Registered Manager and date registered:** Miss Keira Murray 18 July 2018
Person in charge at the time of inspection: Miss Keira Murray	**Number of registered places:** 8
Categories of care: Residential Care (RC): LD – learning disability LD(E) – learning disability – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 6

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 9 September 2020 from 10.15 to 13.35. Short notice of the inspection was provided to the registered manager the afternoon before the inspection, in order to ensure that arrangements could be made to safely facilitate the inspection in the home.

This inspection focused on medicines management within the home. The inspection also assessed progress with any areas for improvement identified at or 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 staff and the manager 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 were examined and/or discussed during the inspection:

- training and competency records for staff managing medicines
- personal medication records
- medicine administration records
- medicine receipt and disposal records
- care plans related to medicines management
- controlled drug record book
- governance and audit records regarding the management of medicines
- medicine storage temperatures

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	1*

*The total number of areas for improvement includes one that has been stated for a second time under the Standards.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Miss Keira Murray, 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.

5.0 What has this service done to meet any areas for improvement identified at the last care inspection (17 August 2019) and last medicines management inspection (19 December 2019)?

No areas for improvement were identified at the last care inspection.

Area for improvement from the last medicines management inspection		
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 31 **Stated:** First time	The registered person shall ensure that personal medication records and handwritten medication administration records are verified by two members of staff before use to ensure that transcribed information is accurate.	**Partially Met**
	Action taken as confirmed during the inspection: There was evidence that personal medication records examined had been verified by two members of staff. Recent examples of handwritten additions to medication administration records had not been verified. **This area for improvement was therefore stated for a second time.**	

6.0 What people told us about this service

We did not meet with residents during the inspection. However, staff interactions with residents were observed to be warm and friendly and staff obviously knew the residents well.

On the day of inspection we met with one member of staff and the registered manager. This staff member said that the residents were well looked after and expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents, manage their medicines and meet their needs and felt well supported by management and other staff.

Feedback methods also 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 envelopes. No questionnaires were completed within the timeframe for inclusion in this report.

No staff members completed the online survey.

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 medical practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times 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.

All 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/stays. These records had been completed in a satisfactory manner. In line with best practice, a second member of staff had checked and signed the records when they were updated to provide a double check that they were accurate.

Copies of residents' prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription. This contributes to confidence that the systems in place are safe.

Obsolete records had been archived appropriately. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the resident.

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 epilepsy, distressed reactions, pain, modified diets etc. Those examined were found to be appropriately maintained.

The management of pain was reviewed. 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 and nutritional supplements. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Some residents cannot take food and/or medicines orally; it may be necessary to administer food and/or medicines via an enteral tube. We reviewed the management of medicines via the enteral route for one resident. An up to date regimen detailing the recommended fluid intake was in place. Records of administration of medicines and water were maintained.

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.

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.

We reviewed the disposal arrangements for medicines. Discontinued medicines were returned to the community pharmacy for disposal and records were maintained.

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 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. Handwritten additions should be verified by two members of staff to ensure accuracy (see section 5.0). An area for improvement identified at the last medicines management inspection was stated for a second time. Records were filed once completed.

Management and staff audited medicine administration on a regular basis within the home. The date of opening was recorded on most medicines so that they could be easily audited. This is good practice and the registered manager agreed to remind staff that should take place for every medicine.

The audits completed during this inspection showed that medicines had been given as prescribed.

Residents may have their medicines administered in food/drinks to assist administration. Care plans detailing how the residents like to take their medicines were in place.

7.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

Residents 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 residents new to the home or returning to the home after receiving hospital care or being admitted for a period of respite care was discussed. 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. Relevant records were accurately written/rewritten.

We reviewed the management of medicines for one short stay resident. Medicines had been accurately received into the home and administered in accordance with the most recent directions. Staff were reminded that the name and quantity of each medicine received and the prescribed dose, form and strength must be recorded on every occasion. Staff were additionally reminded that medicines accepted for administration in compliance aids filled by their own community pharmacy, should be individually identifiable. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

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 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.

We discussed the medicine related incident which had been reported to RQIA since the last inspection. There was evidence that the incident had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

The need for a robust audit system which covers all aspects of medicines management was discussed, to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff. The registered manager agreed to include and follow up on actions plans arising from each medicine audit.

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.

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.

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

8.0 Evaluation of Inspection

The 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 the one area for improvement identified at the last medicines management inspection had been partially addressed and has been stated for a second time. No new areas for improvement were identified. We can conclude overall that the residents were being administered their medicines as prescribed.

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

9.0 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 Miss Keira Murray, 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.

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 Action to be taken by the service

The QIP should be completed and detail the actions taken to address the area 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 the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 31 **Stated:** Second time **To be completed by:** Immediate effect	The registered person shall ensure that personal medication records and handwritten medication administration records are verified by two members of staff before use to ensure that transcribed information is accurate. Ref: 5.0, 7.3 & 7.6
	Response by registered person detailing the actions taken: The medication auditing form has been updated to include that personal medication records and handwritten medication administration records are verified by two staff members before being put into issues, so this will be specifically audited during Registered Managers medication audits. Written and verbal communication has been issued to all staff responsible for medication management to ensure compliance with area for improvement. Registered manager is also completing additional regular checks in addition to monthly medication audits to ensure compliance.

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

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