Inspection Report
5 October 2020

SENSE

Type of Home: Residential Care Home
Address: 41 Edenvale Avenue, Eden, Carrickfergus, BT38 7NP
Tel No: 028 9336 2792
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

This is a residential care home which is registered to provide care for up 10 residents.

2.0 Service details

Organisation/Registered Provider: SENSE **Responsible Individual:** Mrs Colette Gray	**Registered Manager and date registered:** Mrs Senga Knox 18 June 2020
Person in charge at the time of inspection: Mrs Senga Knox	**Number of registered places:** 10 To include people with physical disabilities and/or learning disabilities.
Categories of care: Residential Care (RC): SI – sensory impairment	**Total number of residents in the residential care home on the day of this inspection:** 10

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 5 October 2020 from 13.50 to 17.20.

This inspection focused on medicines management within the home and also assessed progress with any areas for improvement identified at the last care and medicines management inspections.

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

During our inspection we:

- 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 was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drugs records
- care plans related to medicines management
- governance and audit records related to medicines management
- staff training and competency records
- medicine storage temperatures

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Senga Knox, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Enforcement action did not result from the findings of this inspection.

5.0 What has this home done to meet any areas for improvement identified at the last medicines management inspection (28 June 2018) and the last care inspection (28 July 2020)?

<table>
<tr><th colspan="3">Areas for improvement from the last medicines management inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 31

Stated: First time</td><td>The registered person shall ensure that records of the administration of thickening agents are fully and accurately maintained.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was evidence that staff knew the prescribed consistency level of thickened fluids; and when administered this was recorded.</td></tr>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Residential Care Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 13 (7)

Stated: First time</td><td>The registered person shall ensure that the infection prevention and control deficits identified during this inspection are addressed.

This relates specifically to the following:

• The cleanliness of shower chairs/hand soap dispensers / hand rails and under sink areas
• Personal toiletries / wipes and toilet rolls inappropriately stored on toilet cisterns
• Staff wearing jewellery.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
We reviewed the above areas and no further concerns were identified. A new cleaning schedule had been put in place, storage of items had been reviewed and staff were not wearing jewellery.</td></tr>
</table>

6.0 What people told us about this home?

On arrival, residents were relaxing in the lounge. Staff were interactive with the residents and some were involved in activities. It was evident from their interactions that they knew the residents well.

We met with staff on duty and the registered manager. All staff were wearing face masks and aprons. Personal protective equipment signage was displayed. Staff expressed satisfaction with how the home was managed. They said they felt supported in their work and advised they had been provided with the appropriate training to look after residents and meet their needs. It was acknowledged that some staff had worked in the home for several years and were very familiar with their roles and responsibilities within the organisation and the home.

Staff comments included:

- "It's great here; really enjoy it."
- "It doesn't feel like work."
- "I'm happy enough."

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 Inspection Findings

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 is usually done by the GP, medical consultant or the pharmacist.

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 e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were generally well maintained. 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 check that they were accurate. We highlighted a few areas to update in relation to detailing the specific dosage directions for

medicines prescribed on a “when required” basis. However, we acknowledged that the detail was recorded in a separate protocol. The manager confirmed by email on 6 October 2020, that this was addressed immediately after the inspection.

Copies of residents’ prescriptions/ letters were retained in the home so that any entry on the personal medication record could be checked against the prescription. This is good practice.

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, modified diets etc.

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 administereing 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.

We reviewed the management of medicines prescribed on a “when required” basis for the management of distressed reactions. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident’s behaviour and were aware that this change may be associated with pain. As detailed above, although these medicines were rarely required, some further detail was required in the personal medication records regarding the directions. The manager confirmed by email on 6 October 2020, that this was addressed immediately after the inspection. A separate form to record the reason and outcome of administration was available.

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. Details were recorded in the sample of care plans examined.

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.

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. A record of all incoming and outgoing medicines must be maintained.

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 and stock levels were regularly monitored to ensure stock was only ordered as needed. A controlled drugs cabinet was available for use as needed. No stock was held. Staff advised of the cleaning routine for medicine storage areas and it was agreed that this would include the wall mounted hand sanitiser stations in these areas.

We reviewed the disposal arrangements for medicines. Discontinued medicines were returned to the community pharmacy for disposal and records were maintained. Staff were reminded that the date of disposal should be recorded on every occasion. This is necessary to indicate when staff are no longer responsible for the medicine and to facilitate the audit process.

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. A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed. A few queries were highlighted with the manager and staff for close monitoring in relation to topical medicines. The completed records were filed once completed. The manager confirmed that this was being addressed and new records had been put into place immediately following the inspection.

Medicines administration is audited by staff and the manager. We were advised that the governance arrangements for medicines have been a specific focus; and new systems have been developed to ensure their auditing systems are more effective. The date of opening was recorded on all medicines, and a running stock balance was recorded. There was evidence of the spot checks carried out on stock balances during the medicine cycle. These are areas of good practice.

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

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 care 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.

7.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicine 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 should help staff to identify medicine related incidents.

From discussion with the manager and staff, it was evident that they were familiar with the type of incidents that should be reported. We reviewed the medicine related incidents which had been reported to RQIA since the last inspection. These had been reported to the prescriber for guidance, investigated and the learning was shared with staff in order to prevent a recurrence. This included the development of new auditing systems and processes for record keeping.

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. Records of staff training/competency in relation to medicines management including the administration of thickening agents and medicines via the rectal route were maintained.

In addition to training of staff, robust governance and audit processes should be in place to ensure the safe management of medicines. These processes should be effective in determining if the system is running well or requires review. There was evidence that satisfactory processes were in place for medicines management in this home.

8.0 Evaluation of Inspection

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led with regard to the management of medicines.

The outcome of this inspection concluded that the areas for improvement identified at the last medicines management and care inspections had been addressed. No new areas for improvement were identified. We can conclude that overall that the residents were being

administered their medicines as prescribed and safe systems were in place for the management of medicines.

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

9.0 Quality Improvement Plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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