

Inspection Report

Name of Service: The Peninsula Care Home

Provider: Dunluce Healthcare Newtownards Ltd

Date of Inspection: 23 January 2025 & 28 January 2025

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:	Dunluce Healthcare Newtownards Ltd
Responsible Person:	Mr Ryan Smith
Registered Manager:	Mrs Ashley Robinson
Service Profile:	
<p>The Peninsula Care Home is a registered residential care home which provides health and social care for up to 40 residents.</p> <p>The home has two suites which are located on the first floor. The Brent Suite provides care for a maximum of 20 residents living with dementia and the Heron Suite provides care for a maximum of 20 residents with a physical disability and/or aged 65 years or over.</p> <p>Residents' bedrooms have ensuite facilities. Residents have access to a range of communal lounges, dining rooms and an enclosed garden area.</p> <p>The nursing home occupies the same building.</p>	

2.0 Inspection summary

An unannounced inspection took place on 23 January 2025, from 10am to 2pm, and on 28 January 2025, from 11.00am to 1.30pm. The inspection was completed by a pharmacist inspector and a finance inspector. The inspection focused on medicines management and the management of residents' finances and property within the home.

The inspection was undertaken to evidence how medicines and residents' finances 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 and the management of residents' finances. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicines 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.

However, areas for improvement were identified in relation to care planning and records of prescribing for the management of pain, insulin and distressed reactions.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, residents were being administered their medicines as prescribed.

Satisfactory systems were in place for the management of residents' finances.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, and new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

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

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 areas for improvement identified at previous inspection, registration information, and any other written or verbal information received from residents, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

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

Staff 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 rounds were tailored to respect each individual's preferences, needs and timing requirements.

No completed questionnaires or responses to the staff survey were received following the inspection.

3.3 Inspection findings

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

Residents in residential 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 may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a 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 majority of personal medication records reviewed 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 confirm that they were accurate. As detailed below some personal medication records were not up to date in relation to insulin and distressed reaction medications.

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 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. Records of administration included the reason for and outcome of each administration. Care plans were in place but were not up to date with the latest prescribed medication and one personal medication record still included a discontinued medication. An area for improvement was identified.

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.

However, care plans were in not place for the management of regular pain relief medications. An area for improvement was identified.

The management of insulin was reviewed. Care plans were in place when residents required insulin to manage their diabetes. However, they did not detail the current insulin dosage directions, or detail how staff can recognise or manage if the resident's blood sugar was outside of the recommended range. One personal medication record did not include the most recent insulin prescribed. An area for improvement was identified.

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

Medicine 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.

Records reviewed 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 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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Mostly satisfactory arrangements were in place for medicines requiring cold storage. However, one recently received medication which required cold storage was being stored in the medication trolley this was rectified on the day of inspection. Satisfactory arrangements were in place for the storage of controlled drugs.

Satisfactory arrangements were in place for the safe disposal of medicines.

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. Most of the records were found to have been accurately completed. A small number of omissions were brought to the attention of the manager for ongoing monitoring. Records were filed once completed and were 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.

Occasionally, residents may require their medicines to be crushed or added to food/drink to assist administration.

To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the resident's care plan. Management were able to confirm that the prescriber had provided authorisation for this practice. The manager was reminded to update the care plans with sufficient detail to describe how the resident's medicines are administered.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits had been discussed with staff and addressed. The date of opening was recorded on medicines to facilitate audit and disposal at expiry.

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines at the time of admission. Written confirmation of prescribed medicines was obtained from the GP at or prior to admission. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

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.

The audits 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. The audits were discussed in detail with the manager for on-going monitoring.

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.

Medicines management policies and procedures were in place. There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Competency had been assessed following induction and annually thereafter.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

3.3.7 What arrangements are in place for the management of residents' finances?

It is the policy of the home for residents to manage their own monies. However, in line with The Residential Care Homes Regulations (NI) 2005, a safe place was available for residents to deposit items for safekeeping when required. A review of records confirmed that no monies or valuables were held on behalf of residents at the time of the inspection.

Discussions with the manager confirmed that no bank accounts were used to retain residents' monies and no member of staff was the appointee for any resident, namely a person authorised by the Department for Communities to receive and manage the social security benefits on behalf of an individual.

Two residents' finance files were reviewed. Written agreements were retained within both files. The agreements included the details of the weekly fee paid by, or on behalf of, the residents and a list of services provided to residents as part of their weekly fee. Both agreements were signed by the resident, or their representative, and a representative from the home.

There was evidence that a review of residents' agreements was being undertaken at the time of the inspection. The review was to ensure that the agreements showed the current fee paid by residents, including details of any third party payment (top up) paid on behalf of residents. The residents' agreements will be reviewed again at the next RQIA inspection.

Discussions with the manager confirmed that no resident was paying an additional amount towards their fee over and above the amount agreed with the Trusts.

Discussions with the manager confirmed that it was policy for the home to pay for services, such as hairdressing and podiatry, in advance and subsequently invoice the residents' representatives for the services provided.

A review of a sample of invoices issued to residents' representatives showed that the amounts on the invoices reflected the amounts detailed in the records provided by the hairdresser and podiatrist. These records listed the names of the residents availing of the service, the type of service provided and the amount charged to each resident. The hairdresser and podiatrist had signed the records, along with a member of staff, to confirm that the services took place.

The manager informed the inspector that no other transactions were undertaken on behalf of residents. Other items, such as toiletries, were purchased by residents or provided by family members.

A review of one resident's file evidenced that a property record was in place for the resident. The record was updated with additional items brought into the resident's room. The record was checked and signed by two members of staff. The manager was advised to ensure that the full details of the items were recorded, for example, the type and make of television owned by the resident. The property records will be reviewed at the next RQIA inspection.

Discussion with the manager confirmed that no transport scheme was in place at the time of the inspection.

No new finance related areas for improvement were identified during the inspection.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	2*	5*

* the total number of areas for improvement includes four which were carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Ashley Robinson, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Residential Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 13 (4) Stated: First time To be completed by: 23 January 2025	The registered person shall review the management of insulin to ensure that personal medication records and care plans are complete and kept up to date. Ref 3.3.1 Response by registered person detailing the actions taken: The registered manager has updated this and continues to monitor the record of insulin.
Area for improvement 2 Ref: Regulation 13(4) Stated: First time To be completed by: 23 January 2025	The registered person shall review the management of medicines prescribed 'when required' for distressed reactions to ensure that personal medication records and care plans are kept up to date with the latest prescribed medication. Ref 3.3.1 Response by registered person detailing the actions taken: The registered manager has PRN care plans in place and these are monitored with monthly audits or sooner if required
Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022	
Area for improvement 1 Ref: Standard 6 Stated: First time To be completed by: 23 January 2025	The registered person shall ensure person centred care plans are in place for the management of pain and are kept up to date to reflect the resident's current needs. Ref 3.3.1 Response by registered person detailing the actions taken: The registered manager has pain management care plans in place, these will be monitored during monthly audits and updated when required.

<p>Area for improvement 2</p> <p>Ref: Standard 6.6</p> <p>Stated: First time</p> <p>To be completed by: 30 September 2024</p>	<p>The registered person shall ensure that care records in relation to a residents' deprivation of liberty safeguards (DoLS) are kept under review and up to date</p> <hr/> <p>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</p> <p>Ref: 2.0</p>
<p>Area for improvement 3</p> <p>Ref: Standard 6</p> <p>Stated: First time</p> <p>To be completed by: 30 September 2024</p>	<p>The registered person shall ensure that care plans are person centred and reflect the outcomes of the assessment of need of the assessment process</p> <hr/> <p>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</p> <p>Ref: 2.0</p>
<p>Area for improvement 4</p> <p>Ref: Standard 35.7</p> <p>Stated: First time</p> <p>To be completed by: 17 September 2024</p>	<p>The registered person shall ensure that all staff are aware of the importance of hand hygiene and that staff carryout effective hand hygiene measures at appropriate times.</p> <hr/> <p>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</p> <p>Ref: 2.0</p>
<p>Area for improvement 5</p> <p>Ref: Standard 28.3</p> <p>Stated: First time</p> <p>To be completed by: 17 September 2024</p>	<p>The registered person shall ensure that the effectiveness of staff IPC and PPE training on practice and procedures is evaluated as part of quality improvement; and to ensure that training is embedded into practice.</p> <hr/> <p>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.</p> <p>Ref: 2.0</p>

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