The Regulation and Quality Improvement Authority

# Children's Home Inspection Report

## IN045139

## 12 November 2024

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

## 1.0 Service information

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| **Service Type:**<br>Children's Home<br><br>**Provider Type:**<br>Health and Social Care Trust<br><br>**Located within:** South Eastern Health and Social Care Trust | **Manager status:**<br>Registered |
| **Brief description of how the service operates:**<br>This home is registered as a small children's home as defined in The Minimum Standards for Children's Homes (Department of Health) (2023).<br><br>The children living in this home may have had adverse childhood experiences and have been assessed as in need of residential care. Children and young people will be referred to collectively as young people throughout the remainder of this report. | |

## 2.0 Inspection summary

An unannounced inspection took place on 12 November 2024, from 11.40am to 1.40pm. 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. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and young people were administered their medicines as prescribed. No new areas for improvement were identified.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, 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 previous areas for improvement identified, registration information, and any other written or verbal information received from young people, relatives, staff or the commissioning trust.

Throughout the inspection the RQIA inspector will seek to speak with young people, 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

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

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after young people 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.

### 3.3 Inspection findings

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

Young people should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times young peoples' 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.

Young people were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each young person. 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 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. A couple of minor discrepancies were highlighted for immediate corrective action and on-going vigilance.

Obsolete personal medication records had not always been cancelled and archived promptly. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly. This was addressed immediately.

All young people should have care records 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 etc.

The management of distressed reactions and pain was reviewed. Records contained sufficient detail to direct the required care. Medicine records were mostly well maintained. Staff were reminded to record the reason for and outcome of each administration when these medicines are requested.

### 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 young person'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 young people 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 young person could be easily located. It was agreed that the temperature of the medicine storage area would be monitored and recorded on a daily basis, the temperature was satisfactory at the time of the inspection. Satisfactory arrangements were in place for medicines requiring cold storage and 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 young people 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 archived once completed and were retrievable for audit/review.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on medicines so that they could be easily audited.

### 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 or for young people returning from other settings. Written confirmation of prescribed medicines was obtained. 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 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 young people are well looked after and receive their medicines appropriately, staff who administer medicines 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. Medicines management policies and procedures were in place.

## 4.0 Quality Improvement Plan/Areas for Improvement

| | Regulations | Standards |
|---|---|---|
| **Total number of Areas for Improvement** | 0 | 2* |

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

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with the person in charge as part of the inspection process and can be found in the main body of the report.

| **Quality Improvement Plan** | |
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| **Action required to ensure compliance with The Minimum Standards for Children's Homes (Department of Health) (2023)** | |
| **Area for improvement 1**<br><br>**Ref:** Standard 11<br><br>**Stated:** First time<br><br>**To be completed by:**<br>11 May 2024 | The registered person shall ensure that in the review of restrictive practices clear written records are maintained which demonstrates the continuing need for the level of restriction used; proportionate to the presenting levels of risk and necessary to safeguard the health, wellbeing and safety of the young people. Restrictions imposed should be for the shortest possible period and be subject of regular review. |
| | **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.**<br><br>Ref: 2.0 |
| **Area for improvement 2**<br><br>**Ref:** Standard 3<br><br>**Stated:** First time<br><br>**To be completed by:**<br>11 May 2024 | The registered person shall ensure that governance arrangements are put in place to ensure that staff are consistently using a proportionate, consistent, fair and measured response to managing young people's behaviour. |
| | **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.**<br><br>Ref: 2.0 |


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