Inspection Report
14 September 2020

Oak Tree Manor Residential Home

Type of Service: Residential Care Home
Address: 2A Hazel Avenue, Dunmurry, Belfast, BT17 9QU
Tel No: 028 9061 0435
Inspectors: Rachel Lloyd & 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 registered to provide care for up to 51 residents living with dementia. It is situated in the same building as Oak Tree Manor Nursing Home.

2.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Mr Gavin O'Hare-Connolly	**Registered Manager and date registered:** Ms Michelle Montgomery 11 March 2020
Person in charge at the time of inspection: Mr Tiago Moreira (Support Manager)	**Number of registered places:** 51
Categories of care: Residential Care (RC): DE - Dementia	**Total number of residents in the residential care home on the day of this inspection:** 38

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 14 September 2020 from 10.20 to 16.45. A second pharmacist inspector was in attendance from 14.30 onwards. Short notice of the inspection was provided on the morning of 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 support 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 was examined and/or discussed during the inspection:

- training and competency for staff managing medicines
- personal medication records
- medicine administration
- medicine receipt and disposal
- care plans related to medicines management
- controlled drug record books
- 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	4

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mr Tiago Moreira, Support 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 (21 and 22 August 2020) and medicines management inspections (5 September 2018)?

The most recent inspection of the home was an unannounced care inspection undertaken on 21 and 22 August 2020. The report from this inspection had not been issued at the time of this inspection. Any areas for improvement identified will be reviewed at a future care inspection.

Three areas for improvement under the standards were identified at the last medicines management inspection. These were assessed as met at the care inspection on 14 January 2020.

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 knew the residents well.

All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

On the day of inspection we met with four members of staff and the support manager. Several staff said that they felt under pressure at times due to staffing arrangements and record keeping and discussed the difficulties during the Covid-19 pandemic. Although they stated they had received training to look after residents and manage their medicines, they often felt overwhelmed and stated they had "been thrown in at the deep end". Although they generally felt well supported by the teams within the units, several staff were unsatisfied regarding the support/interaction received from management and the registered provider. Staff were however, complimentary about the approachability, positivity and help received regarding the support manager who has recently been appointed.

Feedback methods also included a staff poster and paper questionnaires which were provided 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.

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.

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 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. Staff and management were reminded that all but the current personal medication record should be archived promptly. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the resident. This was agreed and it was noted this was already listed as a task to be completed on a weekly basis on unit noticeboards.

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.

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, specialist medicines administered by e.g. community nurses etc. Those examined were generally found to be appropriately maintained. Two residents prescribed a medicine for administration by community nurses on a three and six monthly basis did not have a care plan in place and it was not clear when these medicines had last been or were next due to be administered. Another resident's care plan was incorrect as to how and where their supply of medicines was obtained; this should be reflected accurately in the care plan. Care planning was identified as an area for improvement.

The reason for the administration of medicines "when required" for distressed reactions was recorded and a care plan was in place; however the outcome of administration was not recorded on every occasion. Staff were reminded of the importance of recording this information to facilitate medication reviews, care assessments etc.

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. Pain assessment charts and records of application and removal of pain relieving patches were in place, but were not always completed consistently. Staff were reminded of the importance of utilising these useful additional records accurately and consistently.

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. Staff were advised that an identified cream and opened containers of nutritional supplements should be stored in the refrigerator as per the manufacturer's instructions.

Two eye medicines were noted to be in use 10 days after their expiry, although they were marked with the date of opening. These were removed from stock immediately. These medicines have a limited shelf life after opening and must be used in accordance with the manufacturer's instructions. An area for improvement, in order to comply with the standards, was identified. Other eye medicines in use were examined and found to be within their expiry.

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. A sample of these records was reviewed. Most of the records were found to have been accurately completed. However, handwritten additions to these records should be verified by two members of staff to ensure their accuracy. A couple of examples whereby the details on the MAR and personal medication record did not match were noted and highlighted to staff for attention. This was identified as an area for improvement. 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 support 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.

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 was discussed. Staff confirmed that arrangements were in place to ensure that they were provided with a list of medicines from the hospital and/or GP 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 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.

We discussed the significant number of medicine related incidents which had been reported to RQIA since the last medicines management inspection. There was evidence that these incidents had been reported to the prescriber for guidance and investigated where necessary. However, it was not always clear that learning was shared with staff in order to prevent a recurrence. The audit system in place does help staff to identify medicine related incidents and

staff were familiar with the type of incidents that should be reported. However, it was not clear that the governance of medicine incidents and audits was identifying trends or driving and sustaining improvement. Action plans were not always produced and/or followed up to allow reflection and learning. Whilst it was acknowledged that the support manager was new to his role in this home, and had just identified this as an issue for review and development, this should be promptly addressed. This was identified as an area for improvement.

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 an induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. An examination of the training matrix and records indicated that staff training in medicines management was up to date with the exception of the registered manager. This training was due to be updated.

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 home was well led with regard to the management of medicines.

The outcome of this inspection identified four areas for improvement and several other areas for attention were highlighted to staff. Whilst we identified areas for improvement, we can conclude that overall, 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 areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mr Tiago Moreira, Support 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 6 **Stated:** First time **To be completed by:** 14 October 2020	The registered person shall ensure that care plans for specific medicines administered or provided by staff not employed by the home are in place and detail when these medicines were first administered, next due for administration and if necessary, how and where from they are obtained. Ref: 7.1
	Response by registered person detailing the actions taken: Care plans are now in place for any specific medicine that is administered by staff not employed by the home including all the relevant information regarding the same.
Area for improvement 2 **Ref**: Standard 32 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that medicines with a limited shelf life after opening are used in accordance with the manufacturer's instructions. Ref: 7.2
	Response by registered person detailing the actions taken: All stocks are reviewed weekly and any medicine with a limited shelf life is used as per guidance and desposed of according to manufacturer's instructions.
Area for improvement 3 **Ref**: Standard 31 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that medication administration records are fully and accurately maintained. Specifically: • Handwritten additions are verified by two members of staff • Entries match personal medication records and reflect the prescriber's most recent instructions. Ref: 7.3
	Response by registered person detailing the actions taken: All manual entries are signed by two members of staff to ensure accuracy of entry and also that this matches the most recent instructions
Area for improvement 4 **Ref**: Standard 30 **Stated:** First time	The registered person shall ensure that the governance of medicine incidents and audits is managed to enable the identification of trends and to drive and sustain improvement. Action plans should be produced and/or followed up to promote reflection and learning. Ref: 7.5

To be completed by: 14 October 2020	
	Response by registered person detailing the actions taken: Audits are conducted on a regular frequency and review of incidents is also carried out to allow for the identification of trends, learning and adjust the practice accordingly

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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