Unannounced Post-Registration Medicines Management Inspection Report
3 May 2018

Greenvale House Residential Home

Type of service: Residential Care Home
Address: 82-84 Mill Hill, Castlewellan, BT31 9NB
Tel No: 028 4377 8280
Inspector: Helen Daly

It should be noted that 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 the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a residential care home with 12 beds that provides care for residents with a range of care needs as detailed in Section 3.0. The residential care home is on the same site as a nursing home.

3.0 Service details

Organisation/Registered Provider: Greenvale House **Responsible Individuals:** Mr Norman Foster Mrs Margaret Foster Mrs Barbara Frances Foster	**Registered Manager:** Mrs Donna Elizabeth Fitzpatrick
Person in charge at the time of inspection: Mrs Donna Fitzpatrick	**Date manager registered:** 20 February 2018
Categories of care: Residential Care (RC) I – old age not falling within any other category DE – dementia	**Number of registered places:** 12

4.0 Inspection summary

An unannounced inspection took place on 3 May 2018 from 12.15 to 16.10.

This was the post-registration inspection in relation to medicines management in this recently registered residential care home, located within Greenvale House Nursing Home. The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

This inspection was underpinned by 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).

Evidence of good practice was found in relation to obtaining prescriptions and ensuring that medicines were available for administration on all occasions and the management of pain and distressed reactions.

Four areas for improvement were identified in relation to the management of medication changes and medication on admission, the standard of maintenance of the personal medication records and the medication administration records, and the auditing systems.

We spoke with three residents who were complimentary regarding the care and the staff in the home.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	3	1

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Donna Fitzpatrick, 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.

4.2 Action/enforcement taken following the most recent care inspection

No further actions were required to be taken following the announced pre-registration care inspection on 21 December 2017.

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

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

- recent inspection reports
- recent correspondence with the home
- the management of incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the home registered.

During the inspection the inspector met with three residents, one care assistant and the registered manager.

A total of ten questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

A sample of the following records was examined during the inspection:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- care plans
- medicines storage temperatures

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 21 December 2017

The most recent inspection of the home was an announced care inspection. There were no areas for improvement identified as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection

This was the first medicines management inspection to the home since registration in December 2017.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager advised that all senior care assistants had received in-house training on the management and administration of medicines in February 2018. This was followed by competency assessments which included supervised medication rounds. Further training had had been requested from the community pharmacist. It was agreed that this training would be tailored to address the issues raised at this inspection. As this training was already arranged an area for improvement was not identified.

The registered manager advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed.

The registered manager advised that robust systems were in place to manage the ordering of prescribed medicines to ensure that adequate supplies were available. There was no evidence to indicate that medicines were omitted due to being out of stock. Antibiotics had been received into the home without delay.

Prescriptions were received into the home and checked before being forwarded to the community pharmacist for dispensing.

We reviewed the management of medicines on re-admission for one resident. The discharge letter had been forwarded to the general practitioner but the personal medication record had not been updated. One entry on the medication administration record had been amended rather than discontinued and a new entry made. Medicines which had been discontinued had not been removed from the medicines trolley. This increased the risk of a discontinued medicine being administered. Similar findings were observed for the management of

medication changes. Some personal medication records had not been updated and discontinued medicines remained on the trolley. These findings were discussed in detail with the registered manager and an area for improvement was identified.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. The registered manager was reminded that the balance recorded for controlled drugs should be brought to zero when they are transferred out of the home.

The registered manager was aware that discontinued or expired medicines are to be returned to the community pharmacist for disposal. Records were maintained.

The majority of medicines were stored safely and securely and in accordance with the manufacturer's instructions. Some discontinued and out of date medicines were removed for disposal. There was no evidence to indicate that these medicines had been administered. More than one supply of some medicines was available on the trolley for a small number of residents i.e. the medicine was available in the monitored dosage system and in its original container. These medicines were moved to the medicines cupboard to reduce the possibility of a medicine being administered twice in error. It was agreed that this would be discussed with staff and monitored closely as part of the management of medication changes.

Areas of good practice

There were examples of good practice in relation to obtaining prescriptions and ensuring that medicines were available for administration on all occasions.

Areas for improvement

Robust procedures must be in place for the management of medicines on admission and medication changes.

	Regulations	Standards
Total number of areas for improvement	1	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The majority of medicines examined had been administered in accordance with the prescriber's instructions. Some discrepancies were discussed with the registered manager. However some audits could not be completed as the date of opening had not been recorded. This had already been noted by the registered manager during her audits and was being addressed with staff. It was agreed that this would continue to be closely monitored.

There were arrangements in place to alert staff of when doses of weekly medicines were due.

A small number of residents were prescribed a medicine to be administered "when required" for the management of distressed reactions. The dosage instructions were recorded on the

personal medication record. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour and were aware that it may be due to pain or infection. Care plans were in place. It was agreed that the care plans would be updated to include a reference to the prescribed medicines. These medicines were used infrequently. Systems were in place to record the reason for and outcome of administration.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Care plans were in place. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. The registered manager confirmed that all residents could verbalise their pain.

The registered manager confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on a resident's health were reported to the prescriber.

A review of the personal medication records indicated that a significant number were not up to date and did not correlate with the medication administration records. Recently prescribed medicines had not been recorded and some medicines which had been discontinued had not been cancelled. Due to the number of prescribed medicines, several residents required more than one personal medication record and this had not been recorded, for example, 1 of 2, 2 of 2. The allergy status was not recorded for some residents and where medicines were administered by the community nursing team these medicines had not been included. Personal medicine records must be up to date and contain all the necessary detail. An area for improvement was identified.

Improvements were also necessary in the standard of maintenance of the medication administration records. Some recently prescribed medicines had not been recorded; however the audit outcomes indicated that the medicines had been administered. There were also a number of random missed signatures for administration. Hand-written updates had not been signed by two members of staff. Medication administration records must be accurately maintained in order to evidence that all medicines are being administered as prescribed. An area for improvement was identified.

The registered manager should ensure that a record of the transfer of medicines to residents' families for administration at home is maintained. It was acknowledged that the medication administration records had been completed to show that the medicines had been administered by family and hence an area for improvement was not identified.

Following discussion with the registered manager and staff, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had good working relationships with healthcare professionals.

Areas of good practice

There were examples of good practice in relation to the management of pain and distressed reactions.

Areas for improvement

Personal medication records must be up to date and reflect the prescribers' most recent directions.

Records of the administration of medicines must be accurately maintained.

	Regulations	Standards
Total number of areas for improvement	2	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The administration of medicines to residents was not observed during the inspection.

Throughout the inspection, it was found that there were good relationships between the staff and the residents. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was clear from discussion and observation of staff, that the staff were familiar with the residents' likes and dislikes.

The residents spoken to at the inspection advised that they were happy in the home. They were complimentary regarding the staff and care in the home.

Residents were observed to be relaxing in the lounge. They were reading newspapers, watching television and chatting with each other, staff and visitors.

As part of the inspection process, we issued 10 questionnaires to residents and their representatives. None were returned. Any comments from residents, their representatives and staff in questionnaires received after the return date will be shared with the registered manager for information and action as required.

Areas of good practice

Observation of the care practices evidenced that staff adopted a person centred approach. Staff communicated with residents in a manner that was sensitive and understanding of their needs.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The inspector discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents. The registered manager advised that arrangements were in place to implement the collection of equality data within Greenvale House.

Written policies and procedures for the management of medicines were in place. These were not examined.

Practices for the management of medicines were audited throughout the month by the registered manager. This included running stock balances for analgesics. The outcomes of this inspection indicate that a robust auditing system is necessary. The audits should include the management of medication changes and medication records. Guidance was provided throughout the inspection. It was agreed that all personal medication records would be re-written and the standard of maintenance of records would be included in the audit process. An area for improvement was identified.

The registered manager confirmed that staff knew how to identify and report incidents and that they were aware that medicine incidents may need to be reported to the safeguarding lead and safeguarding team.

Areas of good practice

There were examples of good practice in relation to identifying issues and seeking help from the community pharmacist to address these. Staff were open to all suggestions to ensure the safe management of medicines and to drive quality improvement.

Areas for improvement

A robust auditing system should be implemented to ensure the safe management of medicines and drive quality improvement.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Donna Fitzpatrick, 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.

7.1 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).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** 3 June 2018	The registered person shall review the systems in place for the management of medication changes and medicines on admission. Ref: 6.4
	Medicines management has been reviewed as advised by the inspector. This includes management of medication changes and medicines on admission. A new robust audit tool has been devised.
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** 3 June 2018	The registered person shall ensure that personal medication records are up to date and contain all the necessary detail. Ref: 6.5
	Response by registered person detailing the actions taken: All personal medications records have been reviewed and checked with their General Practitioners they are up to date and contain all the necessary detail.
Area for improvement 3 **Ref**: Regulation 13 (4) **Stated:** First time **To be completed by:** 3 June 2018	The registered person shall ensure that medication administration records are accurately maintained. Ref: 6.5
	Response by registered person detailing the actions taken: Additional random checks have been introduced by the home manager. Also resident of the day has been introduced which includes their overall medicines management.
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 30 **Stated:** First time **To be completed by:** 3 June 2018	The registered person shall implement a robust audit tool which includes all areas of medicines management. Ref: 6.7
	A robust audit tool has been devised by the allocating chemist and the home manager which includes the advise provided by the inspector. This includes all areas of medicines management. This will commence in the middle of the monthly cycle for the month of June 2018.

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

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