The Regulation and Quality Improvement Authority

Inspection Report

18 July 2022

Greenvale House Residential Home

Type of service: Residential Care Home
Address: 82-84 Mill Hill, Castlewellan, BT31 9NB
Telephone number: 028 4377 8280

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: Greenvale House **Responsible Individuals:** Mrs Barbara Frances Foster Mrs Margaret Foster Mr Norman Foster	**Registered Manager:** Mrs Barbara Frances Foster (Acting)
Person in charge at the time of inspection: Mr Tiernan King, Senior Carer	**Number of registered places:** 12
Categories of care: Residential Care (RC): I – old age not falling within any other category DE – dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 11
Brief description of the accommodation/how the service operates: Greenvale House Residential Home is a registered residential care home which provides health and social care for up to 12 residents. The home is divided over four floors. Bedrooms and living areas are provided on the lower ground, ground and first floors. Office space is provided on the second floor. Greenvale House Nursing Home is located in the same building.	

2.0 Inspection summary

An unannounced inspection took place on 18 July 2022, from 10.20am to 1.30pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management. The areas for improvement identified at the last care inspection will be followed up at the next care inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. Medicines were stored safely and securely. Staff were trained and competent and there were effective auditing processes in place. There was evidence that residents were administered their medicines as prescribed. No new areas for improvement were identified at this inspection.

Based on the inspection findings and discussions held, RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the management team in relation to the management of medicines.

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

3.0 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 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 inspection findings, incidents and correspondence. The inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. Staff and residents views were also obtained.

4.0 What people told us about the service

The inspector met with the senior carer, the deputy manager and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well.

Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs.

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

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

Areas for improvement from the last inspection on 2 December 2021		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2021)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 19.2 **Stated:** First time	The registered person shall ensure that all gaps in employment and reasons for leaving, are explored and reasons recorded. **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.**	**Carried forward to the next inspection**
Area for improvement 2 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that separate records are kept for Greenvale House Residential Home and Greenvale House Nursing Home. **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.**	**Carried forward to the next inspection**
Area for improvement 3 **Ref:** Standard 6.2 **Stated:** First time	The registered person shall ensure that reference is made to Deprivation Of Liberty Safeguards in the residents care plan, and the day to day impact of this in practice. **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.**	**Carried forward to the next inspection**

5.2 Inspection findings

5.2.1 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 the 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 personal medication records reviewed at the inspection were accurate and up to date. In line with safe 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.

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. This is safe practice.

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 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 for three residents. Care plans directing the use of these medicines were in place. Staff knew how to recognise a change in each resident's behaviour, and were aware that the change may be associated with pain, constipation and infection. Directions for use were clearly recorded on the personal medication records and records of administration included the reason for and outcome of each administration. These medicines were used infrequently.

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. Care plans were in place and reviewed regularly.

5.2.2 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. Temperatures of medicine storage areas and medicine refrigerator were monitored and recorded daily to ensure that medicines were stored appropriately.

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

5.2.3 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.

The sample of medicines administration records reviewed had been fully and accurately completed. The 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 were recorded in a controlled drug record book. Satisfactory arrangements were in place for the management of controlled drugs.

Records of the audits which were completed by the senior team were available for inspection. The audits covered record keeping, care planning, controlled drugs and the administration of medicines. Satisfactory outcomes were observed.

5.2.4 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 for residents new to the home or returning from hospital. Written confirmation of the

resident's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed and t the audits completed at the inspection showed that the medicines had been administered as prescribed.

5.2.5 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.

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 learning shared with staff in order to prevent a recurrence. Staff were familiar with the type of incidents which should be reported.

The audits completed at the inspection indicated that medicines were administered as prescribed and records were accurately maintained.

5.2.6 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 they are supported. Policies and procedures should be up to date and readily available for staff.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	3*

* The total number of areas for improvement includes three that have been 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 Mr Tiernan King, Senior Carer, and Mrs Maria Foster, Deputy Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan

Action required to ensure compliance with Residential Care Homes Minimum Standards 2021	
Area for improvement 1 **Ref:** Standard 19.2 **Stated:** First time **To be completed by:** Immediate and ongoing (2 December 2021)	The registered person shall ensure that all gaps in employment and reasons for leaving, are explored and reasons recorded. **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.** Ref: 5.1
Area for improvement 2 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 1 February 2022	The registered person shall ensure that separate records are kept for Greenvale House Residential Home and Greenvale House Nursing Home. **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.** Ref: 5.1
Area for improvement 3 **Ref:** Standard 6.2 **Stated:** First time **To be completed by:** Immediately and ongoing (2 December 2021)	The registered person shall ensure that reference is made to Deprivation Of Liberty Safeguards in the residents care plan, and the day to day impact of this in practice. **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.** Ref: 5.1

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