Unannounced Medicines Management Inspection Report
18 December 2018

Golan View

Type of service: Residential Care Home
Address: 72 Farmhill Road, Arvalee, Omagh, BT79 0JW
Tel No: 028 8224 6684
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 that provides care for up to three residents.

3.0 Service details

Organisation/Registered Provider: Golan View **Responsible Individual:** Mrs Ann McGrath	**Registered Manager:** Mrs Ann McGrath
Person in charge at the time of inspection: Ms Florence Maguire, Senior Carer	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC): I – old age not falling within any other category MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years PH – physical disability other than sensory impairment	**Number of registered places:** 3

4.0 Inspection summary

An unannounced inspection took place on 18 December 2018 from 10.35 to 12.10.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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).

The inspection assessed progress with any areas for improvement identified since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to medicines administration, medicine records and medicine storage.

One area for improvement in relation to the completion of personal medication records was identified.

We spoke with two residents who were complimentary regarding the care and 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	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Ms Florence Maguire, Senior Carer, as part of the inspection process and with Mrs Ann McGrath, Registered Manager, via telephone call (27 December 2018). 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

The most recent inspection of the home was an unannounced care inspection undertaken on 3 May 2018. Other than those actions detailed in the QIP no further actions were required to be taken. 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 home was reviewed. This included the following:

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

During the inspection we met with two residents and the senior carer.

We provided 10 questionnaires to distribute to residents and their representatives, for completion and return to RQIA. We left 'Have we missed you?' cards in the home to inform residents/their representatives, how to contact RQIA to tell us of their experience of the quality of care provided. Flyers providing details of how to raise concerns were also left in the home.

We asked the senior carer to display a poster which invited staff to share their views and opinions 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
- training records

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 3 May 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 25 July 2016

There were no areas for improvement identified as a result of the last medicines management inspection.

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.

Medicines were managed by staff who have been trained and deemed competent to do so. Training had been provided by the community pharmacist in November 2018. Competency assessments were updated annually. Records were available for inspection.

In relation to safeguarding, the senior carer advised that staff were aware of the regional procedures and who to report any safeguarding concerns to. Training had been provided in October 2018.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and to manage medication changes. Written confirmation of medicine regimens was obtained. However, personal medication records were written and updated by only one member of staff. In the interests of safe practice personal medication records should be verified and signed by two trained staff at the time of writing and at each update. An area for improvement was identified.

There were systems in place to ensure that residents had a continuous supply of their prescribed medicines. There was evidence that antibiotics and newly prescribed medicines had been received into the home without delay.

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

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment and the storage of medicines.

Areas for improvement

In the interests of safe practice personal medication records should be verified and signed by two trained staff at the time of writing and at each update.

	Regulations	Standards
Total number of areas for improvement	0	1

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 small discrepancies were discussed with the senior carer for ongoing vigilance.

The senior carer advised that regular analgesia was not prescribed for any residents. All residents could verbalise pain and had a supply of analgesia which could be administered when required.

The senior carer advised that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the resident's health would be discussed with the resident and reported to the prescriber.

Most of the medicine records were well maintained and facilitated the audit process. See also Section 6.4

Audit trails on the administration of medicines were completed approximately monthly by the registered manager. In addition a quarterly management audit was completed.

Following discussion with the senior carer, it was evident that, when applicable, other healthcare professionals were contacted in response to medication related issues. Staff advised that they had excellent working relationships with healthcare professionals involved in resident care.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	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.

We did not observe the administration of medicines during the inspection. The senior care advised that each resident was administered their medicines individually in a location of their choice.

Throughout the inspection, it was found that there were good relationships between the senior carer and the residents. The senior carer was noted to be friendly and courteous; she treated the residents with dignity. It was clear from discussion and observation of the senior carer, that the she was familiar with the residents' likes and dislikes. Residents were observed to be relaxed and comfortable.

We spoke with two residents who were complimentary regarding the care provided and staff in the home. One resident made the following comment: " It is very good here. The staff are kind and the food is good.".

As part of the inspection process, we issued 10 questionnaires to residents and their representatives. Four questionnaires were returned. The responses indicated that they were very satisfied with all aspects of the care.

Any comments from residents and their representatives in questionnaires received after the return date (two weeks) will be shared with the registered manager for information and action as required.

Areas of good practice

The senior carer was observed to listen to residents and to take account of their views.

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.

We 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 would be in place to implement the collection of equality data when necessary.

Written policies and procedures for the management of medicines were in place. They were not reviewed at the inspection.

The senior carer advised that staff knew how to identify and report incidents and were aware that medicine incidents may need to be reported to the safeguarding team.

The governance arrangements for medicines management were examined. The registered manager advised of the auditing processes and how any areas identified for improvement were discussed with staff to address.

Following discussion with the senior carer, it was evident that she was familiar with her role and responsibilities in relation to medicines management. She advised that any concerns in relation to medicines management were raised with the registered manager.

The senior carer spoke positively about her work and advised there were good working relationships in the home with staff and the registered manager. She stated she felt well supported in her work.

One member of staff completed a questionnaire indicating that they were “very satisfied” with the care provided in the home.

Areas of good practice

There were examples of good practice in relation to governance arrangements and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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 Ms Florence Maguire, Senior Carer, and Mrs Ann McGrath, 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 Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 31 **Stated:** First time	The registered person shall ensure that personal medication records are verified and signed by two trained staff at the time of writing and at each update. Ref: 6.4
To be completed by: 17 January 2019	**Response by registered person detailing the actions taken:** All personal medication records are now verified and signed for by two trained staff Ann Mc Grath

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

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