The Regulation and Quality Improvement Authority

Inspection Report

3 June 2021

Golan View

Type of service: Residential Care Home
Address: 72 Farmhill Road, Arvalee, Omagh, BT79 0JW
Telephone number: 028 8224 6684

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: Golan View Responsible Individual: Mrs Ann McGrath	Registered Manager: Mrs Ann McGrath Date registered: 1 April 2005
Person in charge at the time of inspection: Mrs Ann McGrath	**Number of registered places:** 3
Categories of care: Residential Care (RC): I – old age not falling within any other category PH – physical disability other than sensory impairment MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 2
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to three residents.	

2.0 Inspection summary

An unannounced inspection took place on 3 June 2021 between 11.00am and 12.35pm. The inspection was carried out by a pharmacist inspector.

This inspection focused on medicines management within the home and assessed progress with the area for improvement in relation to medicines management identified at the last inspection.

Following discussion with the aligned care inspector, it was agreed that the area for improvement in relation to care issues identified at the last care inspection would be followed up at the next inspection.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were 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 we reviewed information held by RQIA about this home. This included previous inspection findings, incidents and correspondence.

To complete the inspection we reviewed: 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.

During the inspection the inspector:

- spoke to the 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

4.0 What people told us about the service

We met with the manager who wore a face mask and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Residents were outside involved in gardening activities.

The manager said that staff had appropriate training to look after residents and meet their needs. She spoke highly of the support given by staff.

In order to reduce the footfall throughout the home, the inspector did not meet with any residents during the inspection. 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 responses had been received.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last care and medicines management inspections?

Areas for improvement from the last medicine management inspection on 18 December 2018		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
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. **Action taken as confirmed during the inspection**: Observation of the personal medication records confirmed that they were verified and signed by two trained staff at the time of writing and at each update.	**Met**

Areas for improvement from the last care inspection on 3 December 2020		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for improvement 1 **Ref**: Standard 25.6 **Stated:** First time	The registered person shall ensure that the staff duty rota records the grades of the staff working in the 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**

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 residents' needs will 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 and hospital appointments.

The personal medication records reviewed at the inspection 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 provide a double check 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 good practice.

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. The manager advised that staff 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.

Discontinued medicines were returned to the community pharmacy for disposal and records maintained.

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.

A sample of these records was reviewed. They had been fully and accurately completed. The records were filed once completed and were readily retrievable for audit/review.

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

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.

There had been no recent admissions to the home. We discussed the admission process for residents new to the home or returning to the home after receiving hospital care. The manager advised that robust arrangements were in place to ensure that they were provided with an accurate list of medicines from the hospital and this was shared with the resident's GP and the community pharmacist.

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.

The audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported.

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 that staff are supported. Policies and procedures should be up to date and readily available for staff use.

Training on the management of medicines had been provided for all staff in March 2021. Competency assessments had been completed following this training. Records were available for inspection.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

The outcome of this inspection concluded that the area for improvement identified at the last medicines management inspection had been addressed. No new areas for improvement were identified. We can conclude that overall that the residents were being administered their medicines as prescribed.

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

7.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	1*

* The total number of areas for improvement includes one that has 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 Mrs Ann McGrath, Registered 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 The Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 25.6 **Stated:** First time **To be completed by:** 4 December 2020	The registered person shall ensure that the staff duty rota records the grades of the staff working in the 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

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