Unannounced Medicines Management Inspection Report
30 April 2018

Mountview Retreat

Type of service: Residential Care Home
Address: 19 Rocktown Lane, Knockloghrim, Magherafelt, BT45 8QF
Tel No: 028 7964 2382
Inspector: Judith Taylor

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 nine beds that provides care for residents living with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Mr Ciaran Patrick Maynes	**Registered Manager:** Mr Ciaran Patrick Maynes
Person in charge at the time of inspection: Mrs Eileen McAllister (Senior Care Assistant)	**Date manager registered:** 2 December 2014
Categories of care: Residential Care (RC) I – Old age not falling within any other category LD – Learning disability LD(E) – Learning disability – over 65 years 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 PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of registered places:** 9 including: not more than two people requiring use of wheelchairs can be accommodated at any time

4.0 Inspection summary

An unannounced inspection took place on 30 April 2018 from 11.20 to 13.45.

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 training, medicines administration, medicine records and medicines storage.

One area for improvement was identified in relation to overall management of medicines for residents receiving short break care.

Residents said they were happy and content in the home and were noted to be relaxed and comfortable in their environment. They spoke positively about their care and the staff.

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 Mrs Eileen McAllister, Person in Charge and by telephone with Mr Ciaran Maynes, 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 most recent inspection on 30 January 2018. 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 and returned QIPs
- recent correspondence with the home
- the management of incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

A poster was displayed to inform visitors to the home that an inspection was being conducted.

During the inspection the inspector met with three residents and two members of staff.

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 transferred
- policies and procedures
- care plans
- 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 30 January 2018

The most recent inspection of the home was an unannounced 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 dated 27 January 2017

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. An induction process was in place for staff and competency assessments were reviewed as part of the annual appraisal process. Supervision sessions were completed twice yearly. The impact of training was monitored through team meetings, supervision and annual appraisal. Refresher training in medicines management was provided in the last year.

There were largely satisfactory procedures in place to ensure the safe management of medicines during a resident's admission to the home and when the resident was going on temporary absence from the home. However, the management of medicines for short break care should be reviewed. We found that two medicines were not appropriately labelled and staff could not be sure if the medicines with a limited shelf life once opened, had passed the expiry date. One medicine was not listed on the personal medication record. An area for improvement was identified.

Systems were in place to manage the ordering of prescribed medicines to ensure that adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two members of staff. This safe practice was acknowledged.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed.

Discontinued or expired medicines were returned to the community pharmacist.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised.

Areas of good practice

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

Areas for improvement

The management of medicines for short break care should be reviewed to ensure that robust arrangements are in place.

	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.

Most of the medicines examined had been administered in accordance with the prescriber's instructions. The audit trails on one resident's medicines could not be concluded as records of the receipt of medicines were not available and this was discussed with staff and the registered manager for close monitoring.

There was evidence that time critical medicines had been administered at the correct time.

When a resident was prescribed a medicine for administration on a "when required" basis 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 this change may be associated with pain. The reason for and the outcome of administration were recorded. A care plan was maintained.

The sample of records examined indicated that pain relieving medicines were rarely required. Staff confirmed that all residents could communicate pain, and details were recorded in the residents' care files. Staff advised that they were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable.

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

Most of the medicine records were well maintained and facilitated the audit process. Two medicines (for use as needed) were not recorded on the personal medication records and it was agreed that this would be addressed before the end of the day.

It was advised that in the instances where a resident is responsible for the self-administration of some or all of their medicines this should be clearly recorded on the personal medication record; staff were reminded that a record of administration by staff is not necessary.

There was evidence that when medicines were prescribed in multiple doses, a running stock balance of the medicine was maintained. This is good practice.

Following discussion with the registered manager and staff and a review of care files, it was evident that when applicable, other healthcare professionals are contacted in response to the resident's needs.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines. Staff were knowledgeable about the residents' 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.

A system is in place to accommodate any resident who wishes to self-administer their medicines.

The administration of medicines had been completed prior to the time of the inspection. Following discussion with staff and residents, we were informed that residents were administered their medicines in a caring manner, they were encouraged to take their medicines and were given as much time as was needed to take their medicines.

The residents were observed to be content and comfortable in their environment. We met with three of the residents who advised that they had no concerns about their care in the home. Comments included:

"I love it here, it's great."
"The staff look after us."
"We know each other and we like it."

We were informed about the good working relationships with the residents, their relatives and staff. Some of the staff had worked in the home for several years and advised us how familiar they were with each resident's likes and dislikes.

Of the questionnaires that were issued, four were returned from residents and their relatives. The responses indicated that they were very satisfied with all aspects of the care in the home.

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

Areas of good practice

Staff listened to residents and took 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.

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 staff confirmed that there were arrangements in place to implement the collection of equality data within Mountview Retreat.

Written policies and procedures for the management of medicines were in place and readily available for staff use. A sample of these was reviewed at the inspection.

The management of medicine related incidents was reviewed. Staff confirmed that they knew how to identify and report incidents and advised of the procedures followed to ensure that all staff were made aware and to prevent recurrence. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

The registered manager advised of the auditing systems which were completed and how any areas for improvement were shared with staff. A copy of these audits was not available for inspection. It was agreed that these would now be kept in the medicines room for staff reference and for review at inspection.

Following discussion with the registered manager and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any concerns in relation to medicines management were raised with the registered manager. They advised that any resultant action was communicated through team meetings and supervision. Staff advised that they felt well supported in their work and that there were good working relationships in the home.

One online questionnaire was completed by staff within the specified time frame (two weeks). Positive responses were recorded.

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents 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 Mrs Eileen McAllister, Person in Charge and Mr Ciaran Maynes, 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) Minimum Standards for Residential Care Homes (2011)	
Area for improvement 3 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 30 May 2018	The registered person shall ensure that the management of medicines for residents receiving short break care is reviewed. Ref: 6.4
	Response by registered person detailing the actions taken: I acknowledge the findings of the inspector on this inspection and thank her for her advise and communications of the amendements required. Measures have been taken to ensure that whenever there are residents staying at Mountview Retreat on respite care full documentation of that's residents medications wil be available for inspection by the inspector. Also any medications coming into the home will have to be approprately labelled to ensure type of medication, identification of expiry dates are able to be verified. This particular residents kardex was amended to reflect the self administration of particular medications, and all medications that the resident would take, regular and or PRN have been added to the kardex appropriately.

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

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