Inspection Report
3 September 2020

Westlands

Type of Service: Residential Care Home
Address: 2 Westland Road, Cookstown BT80 8BX
Tel No: 028 8672 3922
Inspector: Judith Taylor

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 this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a residential care home which is registered to provide care for up to 29 residents. This includes residents who are permanently accommodated in the home, receiving rehabilitation care or short break care.

2.0 Service details

Organisation/Registered Provider: Northern HSC Trust **Responsible Individual:** Jennifer Welsh (Acting)	**Registered Manager and date registered:** Sean McCartan - 1 April 2005
Person in charge at the time of inspection: Sean McCartan	**Number of registered places:** 29
Categories of care: Residential Care (RC): I – old age not falling within any other category PH – physical disability other than sensory impairment Maximum of three residents in RC-PH category of care. The home is approved to provide care on a day basis only to 4 persons	**Total number of residents in the residential care home on the day of this inspection:** 8

3.0 Inspection focus

This inspection was unannounced and was undertaken by a pharmacist inspector on 3 September 2020 from 11.15 to 14.05.

This inspection focused on medicines management within the home, including assessment of progress with any areas for improvement identified since the last care and medicines management inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to residents
- spoke to staff and management 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

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration
- medicine receipt and disposal
- controlled drugs
- care plans related to medicines management
- governance and audit
- staff training and competency records in relation to medicines management
- medicine storage temperatures

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Sean McCartan, Registered Manager and one other member of staff, 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.

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5.0 What has this service done to meet any areas for improvement identified at the last care inspection (22 November 2019) and last medicines management inspection (2 May 2017)?

No areas for improvement were identified at the last care inspection.

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 31 **Stated:** First time	The registered provider should ensure that medicine administration times on personal medication records and printed medication administration records match and be expressed as the time that medicine administration has taken place.	**Met**
	Action taken as confirmed during the inspection: Following discussion with staff and examination of medicine records, this indicated that the necessary improvement regarding medicine administration times had been made.	
Area for improvement 1 **Ref:** Standard 31 **Stated:** First time	The registered provider should ensure that new entries on personal medication records and handwritten entries on printed medication administration records are checked for accuracy and signed by two competent members of staff.	**Met**
	Action taken as confirmed during the inspection: Staff were aware that this was the expected practice. We observed that handwritten medicine entries on these records had involved two members of trained staff.	

6.0 What people told us about this service

Residents were relaxing in their bedrooms or in the lounge. We met with two residents who were complimentary about their care and the staff.

Comments made included:

- “couldn’t be better”
- “looked after well”
- “very glad to be here”
- “I’m getting on the best”

Staff were warm and friendly and it was evident from their interactions that they knew the residents well.

We met with the one senior carer and the registered manager. Staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed. It was obvious from discussion and observation of staff, that they enjoyed working in the home and had completed the appropriate training to look after the residents and meet their needs.

Feedback methods included a staff poster and paper questionnaires which were provided for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, four questionnaires were received by RQIA. Responses were marked as very satisfied or satisfied.

7.0 Inspection findings

7.1 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 the GP, medical consultant or the pharmacist.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist; or by the hospital pharmacist for those accommodated for a period of rehabilitation.

Personal medication records were in place for each resident. These are records used to list all 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, at hospital appointments.

The personal medication records reviewed at the inspection were well maintained. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated; this provides a double check that they are accurate. Satisfactory arrangements were in place to archive obsolete records. We noted that the resident’s allergy status was missing from two of these records. Staff advised this was recorded on the residents’ care files and would be addressed with immediate effect.

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.

All residents should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, diabetes, pain, etc.

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. We reviewed the management of these medicines; they were infrequently required. Staff advised that they knew how to recognise if the resident was distressed and knew that this could be due to pain. Details of the reason for use and outcome were recorded and a care plan was maintained.

In relation to diabetes, insulin and blood monitoring were completed by community nurses and records maintained. A care plan and policy regarding low or high blood sugar levels were in place.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered as prescribed. Most of the residents could tell staff if they were in pain and when they required pain relieving medicines. The resident's pain management was recorded in their care files.

7.2 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 other allied healthcare professionals regarding new admissions and that residents' medicines were supplied in a timely manner. We acknowledged the processes for recording details of incoming medicines; these also assist with the stock control and ordering process for medicines.

In relation to injectable medicines, these were administered by the community nurses.

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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

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

7.3 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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs, when medicines are administered to a resident. A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed. We noted that there were missing signatures for one inhaled medicine and it was established, following the audit trail, that this medicine had not been administered as prescribed. The registered manager was requested to review this with the resident's GP. Following the inspection, staff confirmed the action taken and this was satisfactory. The completed records were filed once completed.

Management and staff audited medicine administration on a regular basis within the home. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice. The audits completed during this inspection showed that most medicines had been given as prescribed. Some discrepancies were observed in liquid medicines; and in relation to "when required" medicines, we could not conclude the audits as these medicines had been opened some time ago and administration records were archived. It was suggested that a running stock balance should be maintained. This was identified as an area for improvement in order to comply with the standards.

7.4 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.

We reviewed the management of medicines for residents who had a recent hospital stay or were in receipt of short break care. Written confirmation of each resident's medicine regime had been obtained. The residents' personal medication records had been updated to reflect medication changes which had been initiated during the hospital stay. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

Following a resident's period of rehabilitation, it is essential that when they are discharged back to their home, they fully understand their medicine regimes. Staff advised of the systems in place to ensure the resident and their family (as needed) were updated regarding the medicines.

7.5 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.

We discussed medicine related incidents which had been reported to RQIA since the last inspection. These had been managed appropriately.

The audits we completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines as stated above.

7.6 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 Trust and management have a responsibility to check that staff are competent in managing medicines and that staff are supported.

Staff in the home had received induction training which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for training and competency assessments.

8.0 Evaluation of Inspection

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

The outcome of this inspection concluded that the areas for improvement identified at the last medicines management inspection had been addressed. One new area for improvement was identified in relation to audit and is detailed in the Quality Improvement Plan. We can conclude that overall the residents were being administered their medicines as prescribed by their GP.

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

9.0 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 Sean McCartan, Registered Manager and one other member of staff, 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.

9.1 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).

9.2 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 30 **Stated:** First time	The registered person shall review the auditing process to ensure this includes liquid medicines, inhaled medicines and medicines prescribed on a “when required” basis. Ref: 7.3
To be completed by: Immediate and ongoing	**Response by registered person detailing the actions taken:** Future audits will include liquid medicines, inhaled medicines and medicines prescribed on a 'when required' basis.

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

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