Inspection Report

3 August 2022

Greenfield

Type of service: Residential Care Home
Address: 2 Melmount Road, Strabane, BT82 9BT
Telephone number: 028 7188 2381

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: Western Health and Social Care Trust **Responsible Individual:** Mr Neil Guckian	**Registered Manager:** Ms Berenice Laird, Acting
Person in charge at the time of inspection: Ms Berenice Laird, Manager	**Number of registered places:** 28
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:** 16
Brief description of the accommodation/how the service operates: Greenfield is a residential care home which is registered to provide care for up to 28 residents.	

2.0 Inspection summary

An unannounced inspection took place on 3 August 2022, from 11.00am to 2.50pm. 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.

Review of medicines management found that residents were administered their medicines as prescribed. The majority of records were well maintained. Two areas for improvement in relation to staff training and care planning for distressed reactions were identified.

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 medicines management.

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. To complete the inspection the following were reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke with staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with the senior carer and the manager.

Staff were warm and friendly and it was evident from discussions that they knew the residents well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The staff members spoken with expressed satisfaction with how the home was managed and the support provided. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

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. No responses had been received at the time of issuing this report.

5.0 The inspection

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

The last inspection to this residential care home was undertaken by a care inspector on 21 October 2021; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in residential 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 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 best practice, on most occasions, 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. Staff were reminded that this should occur on all occasions and that the date of writing/rewriting should be recorded. It was agreed that this would be monitored through the audit process.

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, pain, modified diets 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 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. 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, infection or constipation. Directions for use were clearly recorded on the personal medication records. Records of administration included the reason for and outcome of administration. Care plans were not in place for two residents and the care plan for the third resident contained limited detail. An area for improvement was identified.

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 when required. Care plans were in place and reviewed regularly.

Satisfactory systems were in place for the management of diabetes. Care plans contained sufficient detail to direct staff on the action to be taken if blood sugar levels were outside the resident's recommended range.

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 the 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 medication administration records reviewed at the inspection had been maintained in a satisfactory manner. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. Records of receipt, administration and disposal were maintained to the required standard in a controlled drug record book.

Management and staff audited medicine administration on a regular basis within the home. In addition, running stock balances were maintained for medicines which were not supplied in the monitored dosage system. The majority of audits completed at the inspection indicated that medicines were administered as prescribed. One discrepancy was discussed with the senior carer and manager for close monitoring.

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. The admission process for residents new to the home or returning from hospital was discussed. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the resident's medicines and this was shared with 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.

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.

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.

The manager advised that staff had received training on medicines management and administration but that records had not been maintained. Records of staff training and competency assessment with regards to medicines management should be available. An area for improvement was identified.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Minimum Standards 2021.

	Regulations	Standards
Total number of Areas for Improvement	0	2

The areas for improvement and details of the Quality Improvement Plan were discussed with Ms Berenice Laird, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with Residential Care Homes Minimum Standards 2021	
Area for improvement 1 **Ref:** Standard 6 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall ensure that care plans are in place for the management of distressed reactions. Ref 5.2.1
	Response by registered person detailing the actions taken: Manager has reviewed the care files of residents who are prescribed medication for the management of distressed reactions and they are now all in place.
Area for improvement 2 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 3 September 2022	The registered person shall ensure that records of staff training and competency assessment in relation to medicines management are maintained and available for inspection. Ref 5.2.6
	Response by registered person detailing the actions taken: The hospital pharmacist has now rolled out medication training for Band 5 staff. Manager is in the process of getting all staff trained. Manager is also in the process of updating all band 5 medication competencies.

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