Unannounced Medicines Management Inspection Report
13 December 2018

Willowview

Type of service: Residential Care Home
Address: 45 Killyleagh Road, Saintfield, BT24 7EH
Tel No: 028 9751 0878
Inspector: Catherine Glover

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 11 residents with care needs as specified in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Willowview **Responsible Individuals:** Mrs Imelda Margaret Flanagan Mrs Elizabeth Joan Dolan	**Registered Manager:** Mrs Imelda Margaret Flanagan
Person in charge at the time of inspection: Mrs Elizabeth (Liz) Dolan	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC) I – Old age not falling within any other category DE – Dementia PH – Physical disability other than sensory impairment	**Number of registered places:** 11 Including a maximum of six residents in RC-DE category of care. RQIA must be consulted before any further persons with diagnosis of dementia are admitted/accommodated

4.0 Inspection summary

An unannounced inspection took place on 13 December 2018 from 10.30 to 13.15.

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 and the majority of medicine records.

Areas for improvement were identified in relation to the management of controlled drugs, the management of warfarin and care planning in relation to the management of distressed reactions and pain.

The resident we spoke to said they were happy in the home and that the staff were excellent.

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	1	2

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Liz Dolan, Registered Person, 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 finance inspection

The most recent inspection of the home was an unannounced finance inspection undertaken on 18 October 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 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.

During the inspection we met with one resident and one of the registered persons.

We provided the senior care assistant with ten questionnaires to distribute to residents and their representatives, for completion and return to RQIA. 'Have we missed you?' cards were left in the foyer of the home to inform residents/their representatives of how to contact RQIA, to tell us of their experience of the quality of care provided. Flyers providing details of how to raise any concerns were also left in the home. Staff were invited to share their views by completing an online questionnaire.

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

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
- medicine audits
- care plans
- training records
- controlled drug record book

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 18 October 2018

The most recent inspection of the home was an unannounced finance 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 24 November 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. Samples of training and competency assessments that had been completed within the last year were provided for inspection. The impact of training was monitored through team meetings, supervision and annual appraisal.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Antibiotics and newly prescribed medicines had been received into the home without delay.

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

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice. However, the controlled drugs which had been received for the commencement of the new monthly

medicines cycle had not been placed into the controlled drugs cabinet and instead had been placed with the rest of the medicines on the shelves in the medicine cupboard. These medicines were placed in the controlled drugs cabinet during the inspection. Controlled drugs which are subject to safe custody regulations must always be stored in the controlled drugs cabinet. An area for improvement was identified.

It was noted by the inspector that the scheduled blood testing for monitoring warfarin, which was due on 29 November 2018, for one resident had not taken place. This was completed by the community nurse during the inspection and the registered person was advised to report this as a medication incident. The incident report indicated that there was no adverse outcome for the resident and the dosage regimen remained unchanged. The arrangements for the management of warfarin should be reviewed and revised to ensure that a similar incident does not occur. An area for improvement was identified.

Discontinued or expired medicines were disposed of appropriately.

With the exception of the controlled drugs discussed previously, medicines were stored safely and securely. Medicine storage areas were clean, tidy and well organised. Supplies of Xalatan eye drops which should be refrigerated until they are in use were observed in the medicine cupboard. The registered person was advised to seek advice from the community pharmacist on whether these were still suitable for use. The registered person was reminded that these eye drops should be stored in accordance with the manufacturer's' specifications.

Areas of good practice

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

Areas for improvement

Areas for improvement were identified in relation to the storage of controlled drugs and the management of warfarin.

	Regulations	Standards
Total number of areas for improvement	1	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly medicines were due.

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. A care plan for the management of distressed reactions had not been completed. An area for improvement was identified.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. The registered person advised that the residents could verbalise any pain. A care plan for the management of pain had not been completed. An area for improvement was identified.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record. Each administration was recorded and care plans and speech and language assessment reports were in place. The registered person was reminded that the prescribed fluid consistency should be recorded on all records relating to thickened fluids.

The registered person 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.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged.

Following discussion with the registered person it was evident that other healthcare professionals are contacted when required to meet the needs of residents.

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

An area for improvement was identified in relation to care planning for the management of distressed reactions and pain.

	Regulations	Standards
Total number of areas for improvement	0	1

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.

The administration of medicines to residents was not observed during this inspection; however the registered person was knowledgeable about the residents' medicines and medical requirements.

It was found that there were good relationships between the staff and the residents. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was clear from

discussion and observation of staff, that the staff were familiar with the residents' likes and dislikes.

We spoke with one resident who said that the staff were excellent, she enjoyed the food and her room was comfortable. She said that she enjoyed trips out with her family and that she was very content in the home.

One questionnaire was returned form a relative within the timeframe for inclusion in this report (two weeks). All of the responses indicated that they were very satisfied with the care provided.

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.

We discussed the 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. Arrangements are place to implement the collection of equality data.

Written policies and procedures for the management of medicines were in place. They were not reviewed on this occasion.

There were robust arrangements in place for the management of medicine related incidents.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

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

The registered person advised that there were good staff relationships within the home and that any issues were discussed during team meetings.

There were no responses to the online staff survey.

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 Liz Dolan, Registered Person, 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be completed by:** 13 January 2018	The registered person shall ensure that controlled drugs which are subject to safe custody legislation are stored in the controlled drugs cabinet. Ref: 6.4
	Response by registered person detailing the actions taken: In place and ongoing from date of inspection
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 **To be completed by:** 13 January 2018	The registered person shall ensure that there is a robust process for the management of warfarin. Ref: 6.4
	Response by registered person detailing the actions taken: Triggers have been incorporated into the Medicine adminstration record and Staff handover book to ensure Staff can monitor District Nursing dates for INR testing and chase up if the test hasn't been carried out. staff have also been trained on follow up testing if an antibiotic has been prescribed to ensure District Nursing has been informed and an unscheduled INR arranged to be carried out in a timely manner. In place and ongoing.
Area for improvement 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** 13 January 2018	The registered person shall ensure that care plans for the management of distressed reactions and pain are completed for the relevant residents. Ref: 6.5
	Response by registered person detailing the actions taken: All careplans have been reviewed and have pain management and PRN medication incorporated. In place and ongoing

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

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