The Regulation and Quality Improvement Authority

Inspection Report

8 April 2021

Barnvale Cottage

Type of service: Residential Care Home
Address: 82b Mill Hill, Castlewellan, BT31 9NB
Telephone number: 028 4377 1378

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: Greenvale House **Responsible Individual:** Mrs Margaret Foster	**Registered Manager:** Mrs Barbara Frances Foster **Date registered:** 18 June 2013
Person in charge at the time of inspection: Mrs Margaret Tate, Senior Carer	**Number of registered places:** 7 The home is approved to provide care on a daily basis only for two persons five days each week (Monday – Friday 09.00 – 16.00). There must be no more than seven persons in the home at any one time.
Categories of care: Residential Care (RC): LD – learning disability LD(E) – learning disability – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 7
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for residents who are living with a learning disability.	

2.0 Inspection summary

An unannounced inspection took place on 8 April 2021 from 10.20am to 12.50pm. The inspection was carried out by a pharmacist inspector.

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to the management of medicines.

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

4.0 What people told us about the service

We met with the senior carer and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after residents and meet their needs. They spoke highly of the support given by management.

In order to reduce the footfall throughout the home, we 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.

Five residents completed and returned the questionnaires. Their responses indicated that they were "very satisfied" with all aspects of the care provided.

5.0 The inspection

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

Areas for improvement from the last inspection on 9 September 2020		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that the identified resident's nutrition care plans are updated to reflect the resident's current nutritional plan of care. Any changes to residents' care files should be signed and dated by the person making the change.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be 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/or hospital appointments.

It was identified that some of these records were not up to date with the most recent prescription and that some dosage directions were unclear. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare

professional. Obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and hence administer medicines incorrectly to the resident. On a small number of records the resident's allergy status had not been recorded. The following improvements were found to be necessary with regard to the personal medication records:

- medication dosage directions should be clearly recorded
- medication changes should be recorded immediately
- obsolete personal medication records should be cancelled and archived
- the date of writing should be recorded
- the resident's allergy status should be recorded

An area for improvement was identified.

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, self-administration etc.

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.

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 residents' 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.

Review of the disposal arrangements for medicines indicated that discontinued medicines were returned to the community pharmacy for safe disposal and records maintained. It was agreed that the reason for the disposal of medicines would be recorded from the date of the inspection onwards.

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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. The majority of the records were found to have been fully and accurately completed. However, correction fluid had been used on two records; this is not acceptable. For one resident, staff had signed that they had administered the incorrect dose of a medicine; following discussion with staff and the manager, it was established that the correct dose had been administered. Medicine administration records must be accurately maintained. An area for improvement was identified.

Management and staff audited medicine administration on a regular basis within the home. The audits did not include all aspects of the management of medicines, for example the standard of maintenance of the personal medication records and the medication administration records. In order to drive and sustain the necessary improvements the registered person should implement a robust auditing system which covers all aspects of the management of medicines. An area for improvement was identified.

The audits completed during this inspection showed that medicines had been given as prescribed. A small number of audits could not be completed because the date of opening had not been recorded. It was agreed that this would be addressed immediately and included in the auditing system.

The medicine cups used to administer medicines to residents were labelled as single use. Therefore, they should be discarded after each use. However, the manager and staff advised that the cups are washed after use and then reused. This matter was discussed with the manager who gave an assurance that the necessary arrangements would be made to ensure that this practice is stopped.

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. Staff advised that robust arrangements were in place to ensure that they were provided with a list of medicines from their GP or a hospital discharge letter that was shared with the resident's GP and the community pharmacist. The need for the personal medication records to be accurately written /rewritten was reiterated.

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.

Management and staff were familiar with the type of incidents that should be reported. A robust auditing system will help in the identification of medication related incidents.

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.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter.

6.0 Conclusion

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan and include the standard of maintenance of the personal medication records and medication administration records and the auditing system.

Although we identified areas for improvement, we can conclude that overall, the residents were being administered their medicines as prescribed by their GP. Based on the inspection findings and discussions held we 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 manager/management team.

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

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with the Residential Care Home Regulations (Northern Ireland) 2005 and the Residential Care Homes Minimum Standards (2011).

	Regulations	Standards
Total number of Areas for Improvement	2	2*

* The total number of areas for improvement includes one that has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Barbara Foster, Registered 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 The Residential Care Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that the personal medication records are fully and accurately maintained. Ref: 5.2.1
	Response by registered person detailing the actions taken: Following inspection all personal medication records where rewritten as appropriate
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that the medication administration records are accurately maintained. Ref: 5.2.3
	Response by registered person detailing the actions taken: The medication administration records are accurately maintained and audits of same have and will be carried out along with the already existing monthly audits
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 9 October 2020	The registered person shall ensure that the identified resident's nutrition care plans are updated to reflect the resident's current nutritional plan of care. Any changes to residents' care files should be signed and dated by the person making the change.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next inspection. Ref: 5.1

Area for improvement 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall implement a robust audit system which covers all aspects of the management of medicines. Ref: 5.2.3 and 5.2.5
	Response by registered person detailing the actions taken: A robust audit system is now in place which covers all aspects of the management of medicines

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