Unannounced Medicines Management Inspection Report
8 August 2018

Beltany House

Type of Service: Residential Care Home
Address: 15 Beltany Road, Omagh, BT78 5NA
Tel No: 028 8224 9902
Inspector: Paul Nixon

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 3 beds that provides respite care for residents living with a learning disability.

3.0 Service details

Organisation/Registered Provider: Western HSC Trust **Responsible Individual:** Dr Anne Kilgallen	**Registered Manager:** See box below
Person in charge at the time of inspection: Mr Sean Greene	**Date manager registered:** Mr Sean Greene Acting – no application required
Categories of care: Residential Care (RC) LD - Learning Disability LD (E) – Learning disability – over 65 years	**Number of registered places:** 3 The home is approved to provide care on a day basis only to one person

4.0 Inspection summary

An unannounced inspection took place on 8 August 2018 from 09.20 to 11.30.

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 during and 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 governance, medicine records, care planning and medicine storage.

No areas for improvement were identified.

The relative of one resident, who arrived to receive respite care during the inspection, spoke positively about the care provided. They were complimentary about the staff and management.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr Sean Greene, Manager, as part of the inspection process and can be found in the main body of the report. Enforcement action did not result from the findings of this inspection.

4.2 Action/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 11 July 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 medicine related incidents reported to RQIA since the last medicines management inspection.

During the inspection the inspector met with the manager, two members of care staff and one resident's representative.

A total of 10 questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA.

At the request of the inspector, the person-in-charge was asked to display a poster in the home which invited staff to share their views of the home by completing an online questionnaire.

We left "Have we missed you?" cards. The cards facilitate residents or residents' representatives who were not present at the time of the inspection to give feedback to RQIA on the quality of service provision. Flyers which gave information on raising a concern were also left in the home.

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
- medicines storage temperatures

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

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 carried out on 11 July 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP will be reviewed by the care inspector. This QIP will be validated by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection carried out on 9 May 2016

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Recommendation 1 **Ref**: Standard 10 **Stated:** First time	The registered person should ensure that the reason for and the outcome of administration of medicines prescribed on a "when required" basis for the management of distressed reactions is recorded on each occasion.	**Met**
	Action taken as confirmed during the inspection: The records of two residents who were prescribed medication for administration on a "when required" basis for the management of distressed reactions were examined. The reason for and the outcome of administration were recorded on each occasion that the medication was administered.	

Action required to ensure compliance with The Residential Care Homes Minimum Standards (2011)		Validation of compliance
Recommendation 2 **Ref**: Standard 6 **Stated:** First time	The registered person should ensure that a pain assessment is completed for each resident as part of the admission process.	**Met**
	Action taken as confirmed during the inspection: None of the residents were prescribed regular pain medication. However, when pain was suspected or "when required" analgesia was administered, a pain assessment was completed.	

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 care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was provided in the last three years. The manager and staff stated that care staff attend epilepsy and rescue medication administration training every two years.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and discharge from the home. Systems were in place to ensure that each resident, on admission, has sufficient supplies of medicines for each period of respite care. There were satisfactory arrangements in place to ensure personal medication records were verified at each admission and to manage any changes to prescribed medicines. Personal medication records were updated and signed by two members of staff or by the prescriber. 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.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and discharge from the home. At discharge, any remaining medicines are returned to the person with caring responsibility.

Appropriate arrangements were in place for administering medicines in disguised form.

Discontinued or expired medicines were disposed of appropriately.

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 good practice in relation to staff training, competency assessment, the management of medicines on admission and discharge and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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.

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.

For those residents prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Administrations were recorded and care plans and speech and language assessment reports were in place.

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 person with caring responsibility.

Medicine records were well maintained and facilitated the audit process.

All medicines in the home had been audited by staff three times each week. Records of these audits were maintained. Each resident's medicines were also audited by two staff at discharge. There was evidence that this system was well embedded into routine practice. The manager advised of the procedures that were followed if a discrepancy was identified.

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.

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.

The residents were attending day care centres at the time of the inspection. However, one new resident arrived for respite care during the inspection. We spoke with the resident's representative, who advised that they were very pleased with the care provided and their relative was very happy in the home.

Staff were knowledgeable regarding the residents' medicines, their likes and dislikes.

None of the questionnaires that were issued for residents' representatives to complete were returned within the allocated timeframe.

Areas of good practice

Staff had a good working knowledge of residents' medicines and their preferred needs.

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 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 within Beltany House.

Written policies and procedures for the management of medicines were in place. These were not examined in detail. Following discussion with staff it was evident that they were knowledgeable regarding the policies and procedures and that any updates were highlighted to them.

A review of the audit records indicated that satisfactory outcomes had been achieved.

There were satisfactory arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. They provided details of the procedures in place to ensure that all staff were made aware of incidents and to prevent recurrence. These usually included reflective practice and supervision. 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.

Following discussion with the staff, it was evident that they were knowledgeable regarding their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with the registered manager; and any resultant action was discussed at team meetings and/or supervision. They spoke positively about their work and advised that there were good working relationships in the home with staff, management and with other healthcare professionals. They stated they felt well supported in their work.

One member of staff shared their views by completing an online questionnaire. They indicated that they were very satisfied with all aspects of the care provided and the management of the home. They stated that “the service provided is person-centred.”

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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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