The Regulation and Quality Improvement Authority

Inspection Report

22 August 2023

Orchard Lodge Care Home

Type of service: Residential Care Home
Address: Desart Lane Close, Armagh, BT61 8BF
Telephone number: 028 3752 6462

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: Kathryn Homes Ltd **Responsible Individual:** Mr Stuart Johnstone	**Registered Manager:** Mrs Adelina Focseneanu (Acting)
Person in charge at the time of inspection: Mrs Adelina Focseneanu	**Number of registered places:** 19
Categories of care: Residential Care (RC): DE – dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 17
Brief description of the accommodation/how the service operates: Orchard Lodge Care Home is a residential care home registered to provide health and social care for up to 19 residents living with dementia. Residents' bedrooms, communal lounge and dining room are located on the ground floor. Residents have access to an enclosed garden. There is a Nursing Home under the same roof which occupies part of the ground floor and the first floor of the building.	

2.0 Inspection summary

An unannounced inspection took place on 22 August 2023, from 10.30am to 1.15pm. This was completed by a pharmacist inspector. The inspection 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.

The area for improvement identified at the last care inspection has been carried forward and will be followed up at the next care inspection.

Review of medicines management found that medicines were stored securely and there were effective auditing processes in place to ensure that staff were trained and competent to manage medicines. Areas for improvement were identified in relation to maintaining accurate personal medication records, medicine related care plans and monitoring and recording the temperature of the medicines refrigerator.

Whilst areas for improvement were identified, RQIA can conclude that overall the residents were being administered their medicines as prescribed.

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 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, information held by RQIA about this home was reviewed. This included previous inspection findings, incidents and correspondence. The inspection was completed by examining 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. 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 care team manager and the manager. Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs.

Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well.

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. At the time of issuing this report, no questionnaires had been received by RQIA.

5.0 The inspection

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

Areas for improvement from the last inspection on 29 June 2023		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 20 (1) (c) (ii) **Stated:** First time	The registered person shall ensure systems in place to monitor staff's registration with NISCC are robust and inclusive of all relevant staff members. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**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 the residents' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, the 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 not up to date with the most recent prescription. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff did not use these records as part of the administration of medicines process. 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 administer medicines incorrectly to the resident. An area for improvement was identified.

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.

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. 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. Directions for use were clearly recorded on the personal medication records. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain. Records included the reason for and outcome of each administration. However, one care plan was not in place to direct staff and one care plan required updating to reflect the most recent prescribed medication.

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. For one resident there was no care plan in place to direct staff. The manager gave an assurance that this would be put in place immediately following the inspection. An area for improvement in relation to medicine related care plans; including distressed reactions and pain management was identified.

Care plans were in place when residents required insulin to manage their diabetes. There was sufficient detail in the care plan to direct staff if the resident's blood sugar was outside the 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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately.

Medicines which require cold storage must be stored between 2ºC and 8ºC to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the current, maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. Appropriate action must be taken if the temperature recorded is outside the recommended range. Review of the medicine refrigerator temperature logs identified the maximum temperature readings were consistently above 8ºC. The readings taken by the inspector on the day of the inspection were within the reference range indicating that the medicines refrigerator was working properly. Staff advised that the readings were a result of recording the room temperature in the incorrect column of the record book. The manager provided assurances that staff would receive training/supervision on how to accurately monitor and record the temperature of the medicines refrigerator and that this would be monitored through the home's auditing system. An area for improvement was identified.

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.

A sample of the medicines administration records was reviewed. All of the records reviewed were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for audit.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. Review of the controlled drug record book identified the date of return to pharmacy/transfer for a small number of controlled drugs had not been recorded and balances had not been brought to zero; this was discussed with the manager for corrective action and close monitoring.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all boxed medicines so that they could be easily audited. This is good practice.

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new residents or residents returning from hospital. Written confirmation of the resident's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

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. A robust audit system will help 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.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

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.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal.

As detailed in section 5.2.2 staff should receive training/supervision on how to accurately monitor and record the temperature of the medicines refrigerator.

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 Regulations (Northern Ireland) 2005 and The Residential Care Homes Minimum Standards 2022.

	Regulations	Standards
Total number of Areas for Improvement	2*	2

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Adelina Focseneanu, 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 20 (1) (c) (ii) **Stated:** First time **To be completed by:** Immediately and ongoing (29 June 2023)	The registered person shall ensure systems in place to monitor staff's registration with NISCC are robust and inclusive of all relevant staff members. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate action required (22 August 2023)	The registered person shall ensure that accurate and up to date personal medication records are maintained and that obsolete records are cancelled and archived. Ref: 5.2.1 **Response by registered person detailing the actions taken:** All out of date Kardexs removed and all records replenished and updated. Same reviewed on an ongoing basis via medication audits
Action required to ensure compliance with Residential Care Homes Minimum Standards 2022	
Area for improvement 1 **Ref:** Standard 6 **Stated:** First time **To be completed by:** Immediate action required (22 August 2023)	The registered person shall ensure that care plans are in place to direct staff when residents are prescribed medicines for pain management and medicines on a "when required" basis for distressed reactions. Ref: 5.2.1 **Response by registered person detailing the actions taken:** All care plans audit and reviewed and upadated where required. Care plans implemented for PRN medication and distressed reaction where those Residents are prescribed these medications.

Area for improvement 2 **Ref:** Standard 32 **Stated:** First time **To be completed by:** Immediate action required (22 August 2023)	The registered person shall ensure that the current, maximum and minimum temperatures of the medicines refrigerator are monitored and recorded each day and that appropriate action is taken if the temperature recorded is outside the recommended range of 2-8ºC. Ref: 5.2.2
	Response by registered person detailing the actions taken: Fridge removed from and placed and secured on top of worltop. All sataff aware to record and report any temperature out of range

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

RQIA, 1st Floor
James House
Gasworks
2 – 4 Cromac Avenue
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care