The Regulation and Quality Improvement Authority

Inspection Report

9 June 2022

Gortacharn

Type of service: Residential Care Home
Address: 21 Nutfield Road, Lisnaskea, Co. Fermanagh, BT92 0LB
Telephone number: 028 6772 1030

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: Gortacharn **Responsible Individuals:** Mr Richard Trimble Mrs Robena Heather Trimble	**Registered Manager:** Mrs Beena Joseph **Date registered:** 26 March 2020
Person in charge at the time of inspection: Mrs Beena Joseph	**Number of registered places:** 15
Categories of care: Residential Care (RC): I – old age not falling within any other category PH – physical disability other than sensory impairment	**Number of residents accommodated in the residential care home on the day of this inspection:** 13
Brief description of the accommodation/how the service operates: Gortacharn is a residential care home which is registered to provide care for up to 15 residents. There is a nursing home located in the same building and the registered manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 9 June 2022, from 10.45am to 3.45pm. 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.

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.

Review of medicines management found that the majority of medicines were administered as prescribed. Arrangements were in place to ensure that staff were trained and competent in medicines management and records were well maintained. However, areas for improvement were identified in relation to the management of eye preparations and the storage of prescribed medicines in residents' bedrooms.

Although areas for improvement 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, the team leader 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 training received. 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 senior carer for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, nine residents/relatives had completed and returned questionnaires. Their responses indicated that they were satisfied/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 the last inspection?

Areas for improvement from the last inspection on 13 January 2022		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 27.1 **Stated:** First time	The registered person shall ensure the following environmental matters are attended to: • the sluice room door should be secured; • the odour should be addressed in an identified ensuite bathroom; • the stained flooring in three identified areas should be repaired/replaced; • the damaged bedframe in one bedroom should be addressed.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is 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 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 safe practice, 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.

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 the management of distressed reactions was reviewed for two 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. Care plans directing the use of these medicines were available; one was updated during the inspection to reflect a recent change in the resident's prescribed medicine. Records of administration and the reason for and outcome of administration were recorded.

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 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.

A number of prescribed inhalers, eye preparations and external medicines were stored in residents' bedrooms. The manager should risk assess the storage of prescribed medicines in

residents' bedrooms to ensure they are stored safely and securely. The administration of these medicines should be included in audit processes. An area for improvement was identified.

Temazepam is a Schedule 3 controlled drug which should be stored in the controlled drug cupboard. One supply of temazepam tablets was observed on the medicines trolley. These were transferred to the controlled drug cupboard during the inspection and assurances were provided that temazepam would be stored appropriately from the date of the inspection onwards.

Appropriate arrangements were in place for the 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.

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 records had been completed in a satisfactory manner.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The records of receipt, administration and disposal of controlled drugs 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 some medicines. The majority of audits completed at the inspection indicated that medicines were administered as prescribed. However, discrepancies were observed in the administration of five supplies of eye preparations. The manager should review the management of eye preparations to ensure they are administered as prescribed. An area for improvement was identified.

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.

The management of medicines for two residents who had a recent hospital stay and were discharged back to this home was reviewed. Hospital discharge letters had been received and a copy had been forwarded to the resident's GP. The residents' personal medication records had been updated to reflect medication changes which had been initiated during the hospital stay. Medicines had been accurately received into the home and administered in accordance with the most recent directions. There was evidence that staff had followed up any

discrepancies in a timely manner to ensure that the correct medicines were available for administration.

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 medicine related incident which had been reported to RQIA since the last inspection was discussed. There was evidence that the incident had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

As detailed in Section 5.2.3, the majority of medicines were being administered as prescribed. However, a number of audit discrepancies in the administration of eye preparations were identified at the inspection. The manager agreed to ensure that the administration of eye preparations would be closely monitored.

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 for staff.

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. A written record was completed for induction, annual update training and competency assessments.

Medicines management policies and procedures were available in the treatment room.

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 (Northern Ireland) 2005 and Residential Care Homes Minimum Standards 2011.

	Regulations	Standards
Total number of Areas for Improvement	2	1*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Beena Joseph, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

<table>
<tr><td colspan="2">Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 13 (4)

Stated: First time

To be completed by:
From the date of inspection
(9 June 2022)</td><td>The registered person shall ensure that all medicines are stored safely and securely. A risk assessment should be in place for the storage of prescribed medicines in residents' bedrooms.

Ref 5.2.2</td></tr>
<tr><td>Response by registered person detailing the actions taken:
All prescribed mediactions like eye ointments and inhalers were removed from the patient's bed room with their consent and stored now in the treatment room.If any resident requests self administration of eye ointment or inhalers staff will complete a risk assessment and the relevant forms will be completed as per home policy.The nurse manager will review this on a regular basis to manatian the safe storage of prescribed medications.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Regulation 13 (4)

Stated: First time

To be completed by:
From the date of inspection
(9 June 2022)</td><td>The registered person shall review the management of eye preparations to ensure they are administered as prescribed.

Ref: 5.2.3 & 5.2.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Reviewed the residents with prescribed eye preparations and made sure it is administered properly as prescribed and also recorded accurately.The registered manager is monitoring and auditing this regularly to ensure the compliance.</td></tr>
<tr><td colspan="2">Action required to ensure compliance with Residential Care Homes Minimum Standards 2011</td></tr>
<tr><td rowspan="2">Area for Improvement 1

Ref: Standard 27.1

Stated: First time

To be completed by:
28 February 2022</td><td>The registered person shall ensure the following environmental matters are attended to:
• the sluice room door should be secured;
• the odour should be addressed in an identified ensuite bathroom;
• the stained flooring in three identified areas should be repaired/replaced;
• the damaged bedframe in one bedroom should be addressed.</td></tr>
<tr><td>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Ref: 5.1</td></tr>
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