The Regulation and Quality Improvement Authority

Inspection Report

21 June 2021

Gortacharn

Type of service: Nursing Home
Address: 21 Nutfield Road, Lisnaskea, 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 Individual(s):** Mr Richard James 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:** 40 This number includes a maximum of four persons in category NH-LD.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) – physical disability other than sensory impairment – over 65 years TI – terminally ill LD – learning disability	**Number of patients accommodated in the nursing home on the day of this inspection:** 39
Brief description of the accommodation/how the service operates: This is a nursing home which provides care for up to 40 patients. It is on the same site as Gortacharn Residential Care Home.	

2.0 Inspection summary

An unannounced inspection took place on 21 June 2021, between 10.15am and 3.00pm. The inspection was carried out by a pharmacist inspector.

This inspection focused on medicines management within the home.

The inspection also assessed progress with the areas for improvement identified in relation to medicines management at the last care inspection. Following discussion with the aligned care inspector, it was agreed that the remaining areas for improvement identified at the last care inspection would be followed up at the next 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.

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

4.0 What people told us about the service

We met with two nurses 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 patients well. Patients were observed to be relaxing in lounges/bedrooms throughout the home.

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

In order to reduce footfall throughout the home, the inspector did not meet with any patients during the inspection. Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report no responses had been received.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at the last medicines management and care inspections?

No areas for improvement were identified at the last medicines management inspection on 22 January 2019.

Areas for improvement from the last care inspection on 16 February 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 14 (2)(a) **Stated:** First time	The registered persons must ensure that all areas of the home to which patients have access are free from hazards to their safety. With specific reference to ensuring that: • chemicals are securely stored in keeping with COSHH legislation • the sluice room is kept locked • combustible items are removed from the identified bathroom • potential trip hazards are reviewed • all grades of staff are aware of their responsibility to report and action any actual or potential hazards.	**Carried forward to the next inspection**
	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.	
Area for improvement 2 **Ref:** Regulation 16 (2) (b) **Stated:** First time	The registered person shall ensure that a review of all patients care records is completed and where a medical history remains relevant a care plan is implemented.	**Carried forward to the next inspection**
	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.	
Area for improvement 3 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the environmental and infection prevention and control issues identified during this inspection are urgently addressed. With specific reference to:	**Carried forward to the next inspection**

	• the storage of patient equipment and/or furniture within en- suites and communal bathrooms/toilets • cleaning clothes are reviewed • light pull cords are covered • furniture with surface damage is repaired/replaced • the bath panel is replaced hoist slings are stored appropriately and decontaminated between use.	
	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.	
Area for improvement 4 **Ref:** Regulation 27 (4) (b) **Stated:** First time	The registered person shall take adequate precautions against the risk of fire. With specific reference to ensuring that: • fire doors are able to close effectively • the use of a multi block electric extension lead in an identified patient's bedroom is reviewed.	**Carried forward to the next inspection**
	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.	

Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		Validation of compliance summary
Area for improvement 1 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure that staff are provided with training specific to IDDSI and are knowledgeable regarding patients' SALT recommendations.	**Met**
	Action taken as confirmed during the inspection: All staff including nurses, care assistants and kitchen staff received training on modified diets and the International Dysphagia Diet Standardisation Initiative (IDDSI) in April 2021. Records were available for inspection. Patient's individual recommendations were readily available for staff. Care plans and speech and language recommendations were up to date.	
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time	The registered person shall ensure that prescribed medicines are securely stored at all times within the home.	**Met**
	Action taken as confirmed during the inspection: This area for improvement related to the storage of laxatives and food supplements on top of the medicines trolley during the medicine round. This had been reviewed to ensure that medicines were stored securely under the direct supervision of the nursing staff at all times.	
Area for improvement 3 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that supplementary recording charts specific to repositioning and prescribed topical creams are reviewed to include: • the recommended frequency of repositioning • the direction for use of prescribed topical creams • 'gaps' in the recording of prescribed topical creams are monitored by management and addressed • the patient's full name is recorded within supplementary charts.	**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?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' 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.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. 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 hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had checked and signed the personal medication records when they are written and updated to provide a double check that they are accurate.

Copies of patients' 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.

All patients 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.

Patients 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 patient's distress and if the prescribed medicine is effective for the patient.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Directions for use were clearly recorded on the personal medication records and the reason for and outcome of administration were recorded.

Care plans directing the use of these medicines were available in the medicines file. However, one care plan was not up to date; this was addressed during the inspection.

The management of pain was discussed. Care plans were in place and there was evidence that medication was administered as prescribed. Staff advised that they were familiar with how each patient expressed their pain. One care plan had not been updated following a recent change in medication; this was addressed during the inspection.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

We reviewed the management of thickening agents and nutritional supplements for four patients. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained. Records of the training which had recently been completed were available for inspection.

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 patient'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 patients required them. Nurses 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 patient could be easily located.

Satisfactory systems 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 patients 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). A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. The records were filed once completed and were readily retrievable for audit/review.

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 were recorded in a controlled drug record book.

Management audited medicine administration on a regular basis within the home. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice. It was agreed that the audits would be further developed to include reviewing care plans in relation to medicines management and the supplementary records for external medicines.

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 manager advised that the admission process for patients new to the home or returning to the home after receiving hospital care had recently been reviewed to ensure that nurses follow up any discrepancies in a timely manner. Nurses were aware that it was unacceptable for medicine doses to be omitted due to stock supply issues. The manager advised that she intends to carry out an audit on the admission process for all new/returning patients.

We reviewed the management of medicines for one recent admission. A hospital discharge letter had been received and a copy had been forwarded to the patient's GP. The patient's personal medication record correlated with the hospital discharge letter. Medicines had been accurately received into the home and administered as prescribed.

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 audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. 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.

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 patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported. Policies and procedures should be up to date and readily available for staff use.

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 and competency assessments.

Nurses had received refresher training on the management of medicines in May 2021.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

The outcome of this inspection concluded that the areas for improvement in relation to medicines management identified at the last inspection had been addressed. No new areas for improvement were identified. We can conclude that overall medicines were administered as prescribed.

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

7.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	4*	1*

* The total number of areas for improvement includes five that have been 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.

Quality Improvement Plan

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	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 16 (2) (b) **Stated:** First time **To be completed by:** 16 March 2021	The registered person shall ensure that a review of all patients care records is completed and where a medical history remains relevant a care plan is implemented.
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The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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