

Inspection Report

18 November 2021



Cairngrove

Type of service: Nursing Home
Address: Balmoral Avenue, Rathfriland Road,
Newry BT34 1JS
Telephone number: 028 3026 6442

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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: Cairnhill Home 'A' Ltd	Registered Manager: Mr James Digney
Responsible Individual: Mr Charles Anthony Digney	Date Registered: Acting – No application required
Person in charge at the time of inspection: Mr James Digney	Number of registered places: 23
Categories of care: Nursing Home (NH) LD – Learning disability. LD(E) – Learning disability – over 65 years.	Number of patients accommodated in the nursing home on the day of this inspection: 23
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 23 patients who have a learning disability. Patients' bedrooms are situated over two floors and patients have access to communal lounges, a dining room and gardens.	

2.0 Inspection summary

An unannounced inspection took place on 18 November 2021 between 9.30am and 12.50pm. This inspection was conducted by a pharmacist inspector.

This inspection focused on medicines management within the home.

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

Review of medicines management found that patients were being administered their medicines as prescribed. There were robust arrangements for auditing medicines and medicine records were well maintained. Arrangements were in place to ensure that staff were trained and competent in medicines management.

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. 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.

4.0 What people told us about the service

The inspector met with the one member of staff and the manager.

Staff were warm and friendly and it was evident from their interactions that they knew the patients well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The staff member spoken with expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after patients and meet their needs. They said that the manager was very supportive of staff and 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 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 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 last inspection?

Areas for improvement from the last inspection on 1 September 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 12 (1) (a)(b) Stated: First time	The registered person shall ensure that the appropriate documentation is reviewed and updated following any fall in the home. A 24 hour post falls proforma review should be conducted to ensure that the appropriate actions have been taken.	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 30 Stated: First time	The registered person shall ensure that notifiable events to RQIA are submitted in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.	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 the Care Standards for Nursing Homes (April 2015)		Validation of compliance summary
Area for improvement 1 Ref: Standard 4 Criteria (9) Stated: First time	The registered person shall ensure that when a patient is deemed at risk of pressure damage, a care plan is in place to guide staff in the pressure management plan which should include frequency of repositioning where appropriate. Contemporaneous records of repositioning must be maintained at the time of repositioning and include evidence of skin checks.	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 medical 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 the GP, the 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 or hospital appointments. The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to provide a double check that they were 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. The management of medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed. 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 care plans directing the use of these medicines were available in the medicines file. These medicines were rarely used

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans were in place and pain assessment tools were used as necessary.

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. The management of thickening agents was reviewed for three patients. For each patient, a speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

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. 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 patient could be easily located. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

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 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) or occasionally handwritten MARs, when medicines are administered to a patient. A sample of these records was reviewed. The records were found to have been completed to the required standard.

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 are recorded in a controlled drug record book. Robust arrangements were in place for the management of controlled drugs. The controlled drugs record books had been maintained to the required standard.

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 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.

The management of medicines was reviewed for one patient who had been admitted to this home. The medicines prescribed had been confirmed with the resident's GP practice as part of the admission process. The personal medication record had been accurately written and signed by two members of staff. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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.

The audits completed at the inspection indicated that medicines had been 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 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 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.

Records of staff training and competency assessment in relation to medicines management were available for inspection.

6.0 Conclusion

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

Based on the inspection findings and discussions held, RQIA was satisfied that safe systems were in place for the management and administration of medicines. Patients were administered their medicines as prescribed.

RQIA 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	2*	1*

* the total number of areas for improvement includes three which are carried forward for review at the next inspection.

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Mr. James Digney, Manager as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 12 (1) (a)(b) Stated: First time To be completed by: With immediate effect	<p>The registered person shall ensure that the appropriate documentation is reviewed and updated following any fall in the home.</p> <p>A 24 hour post falls proforma review should be conducted to ensure that the appropriate actions have been taken.</p>
	<p>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.</p> <p>Ref: 5.1</p>
Area for improvement 2 Ref: Regulation 30 Stated: First time To be completed by: With immediate effect	<p>The registered person shall ensure that notifiable events to RQIA are submitted in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005.</p>
	<p>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.</p> <p>Ref: 5.1</p>
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 Ref: Standard 4 Criteria (9) Stated: First time To be completed by: 1 October 2021	<p>The registered person shall ensure that when a patient is deemed at risk of pressure damage, a care plan is in place to guide staff in the pressure management plan which should include frequency of repositioning where appropriate.</p> <p>Contemporaneous records of repositioning must be maintained at the time of repositioning and include evidence of skin checks.</p>
	<p>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.</p> <p>Ref: 5.1</p>



The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
 [@RQIANews](https://twitter.com/RQIANews)