Inspection Report

25 May 2023

Glencarron

Type of service: Nursing Home
Address: 6 Creamery Road, Crossmaglen, BT35 9AD
Telephone number: 028 3086 8366

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: Glencarron Homes Ltd **Responsible Individual:** Mrs Bridget Liddy & Mr Brendan Liddy	**Registered Manager:** Ms Oonagh Grant **Date registered:** 21 December 2011
Person in charge at the time of inspection: Ms Oonagh Grant	**Number of registered places:** 44 This number includes a maximum of four patients assessed as NH-DE and a maximum of ten patients in categories NH-PH & NH-PH(E). There shall be a maximum of two named patients within NH-LD. The home is also approved to provide care on a day basis for a maximum of nine patients or a maximum of five patients of high dependency.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia LD – learning disability PH(E) - physical disability other than sensory impairment – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 43
Brief description of the accommodation/how the service operates: Glencarron is a nursing home registered to provide nursing care for up to 44 patients. Patients' bedrooms are located over two floors and patients have access to communal lounges and dining rooms.	

2.0 Inspection summary

An unannounced inspection took place on 25 May 2023, from 10.30am to 3.00pm. This 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. The areas for improvement identified at the last care inspection have been carried forward and will be followed up at the next care inspection.

Review of medicines management found that medicine records and medicine related care plans were well maintained. Staff were trained and competent to manage medicines.

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan and include the management of thickening agents and temperature records for medicines refrigerators.

Whilst areas for improvement were identified, it was concluded that overall, with the exception of a small number of medicines, the patients were being administered their medicines as prescribed.

RQIA would like to thank the 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 nursing staff and the manager.

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

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, one questionnaire had been returned and indicated that they were satisfied with the care provided in Glencarron.

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 23 March 2023		
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 13 **Stated:** Second time	The registered person shall ensure that all staff employed in the home completes training on Deprivation of Liberty. **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.**	**Carried forward to the next inspection**
Area for improvement 2 **Ref:** Standard 37.5 **Stated:** First time	The registered person shall ensure that staff duty rotas are not altered using white correction fluid in order that the previous records can be read in accordance with best practice in record keeping. **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.**	**Carried forward to the next inspection**
Area for improvement 3 **Ref:** Standard 41 **Stated:** First time	The registered person shall ensure that staff, patient and patient relative/representative meetings take place on a regular basis and at a minimum quarterly and that records are kept which include: • The date of all meetings; • The names of those attending; • Minutes of discussions; and • Any actions agreed.	**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 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.

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 state 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.

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 distressed reactions was reviewed. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. Most of the records included the reason for and outcome of each administration. The manager gave an assurance that this would be monitored and that regular use would be referred to the patients' GP.

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 and pain assessments were in place and reviewed regularly.

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. A speech and language assessment report and care plan was in place. However, records of prescribing and administration did not include the recommended consistency level. An area for improvement was identified.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient'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 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.

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. Temperatures of medicine storage areas were not monitored or recorded to ensure that medicines were stored appropriately (at or below 25oC). Assurances were provided that the room temperature would be accurately recorded each day and that this would be monitored through the home's revised auditing system.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C 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, to then reset the thermometer and to document the appropriate action taken if the temperature is outside the recommended range. Temperature records were maintained for the medicines refrigerator however, on numerous occasions the maximum temperature was above the recommended range and no action had been taken or documented. 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 patients 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. However, some handwritten medicines administration records had not been signed and verified by two staff to ensure accuracy. The manager gave an assurance that this would be brought to the attention of all nurses and will be closely monitored.

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. There were satisfactory arrangements in place for the management of controlled drugs. Records were maintained to the required standard.

Management and staff audited medicine administration on a regular basis within the home. The inspector discussed the types of audits completed and advice was given regarding the implementation of a monthly management audit to over all aspects of medicines management. The date of opening was recorded on all boxed medicines so that they could be easily audited. This is good practice. The audits completed at the inspection indicated that the majority of medicines were administered as prescribed.

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 patients or patients returning from hospital. Written confirmation of the patient'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 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 the learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. A small number of minor discrepancies were highlighted to the manager for close monitoring.

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 they staff are competent in managing medicines and that 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.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	1	4*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Oonagh Grant, Registered 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** Immediate and ongoing (25 May 2023)	The registered person shall review the management of thickening agents to ensure that records of prescribing and administration are accurately maintained. The recommended consistency level should be recorded on all records. Ref: 5.2.1
	Response by registered person detailing the actions taken: Management of thickening agents recorded in choking risk assessment,care plan,on information sheet for catering staff ,in care assistant file and on MARS.
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 13 **Stated:** Second time **To be completed:** Immediate action required (23 March 2023)	The registered person shall ensure that all staff employed in the home completes training on Deprivation of Liberty.
	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
Area for improvement 2 **Ref**: Standard 37.5 **Stated:** First time **To be completed:** Immediate action required (23 March 2023)	The registered person shall ensure that staff duty rotas are not altered using white correction fluid in order that the previous records can be read in accordance with best practice in record keeping.
	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
Area for improvement 3 **Ref:** Standard 41 **Stated:** First time **To be completed by:** Immediate action required (23 March 2023)	The registered person shall ensure that staff, patient and patient relative/representative meetings take place on a regular basis and at a minimum quarterly and that records are kept which include: • The date of all meetings; • The names of those attending; • Minutes of discussions; and • Any actions agreed.

	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
Area for improvement 4 **Ref**: Standard 30 **Stated:** First time **To be completed by:** With immediate effect (25 May 2023)	The registered person shall ensure that maximum, minimum and current temperatures of medicine refrigerators are accurately monitored and recorded and that a record is maintained of the corrective action taken if the temperature is outside the recommended range. Ref: 5.2.2
	Response by registered person detailing the actions taken: More stringent records now being kept.Weekly monitoring in place and notice on fridge reminding staff to complete daily records.

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

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