The Regulation and Quality Improvement Authority

Inspection Report

5 October 2021

Orchard Grove

Type of service: Residential Care Home
Address: 7 The Square, Clough, BT30 8RB
Telephone number: 028 4481 1672

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: Orchard Grove **Responsible Individuals:** Mr Craig Cecil Emerson & Mr Ian George Emerson	**Registered Manager:** Ms Deirdre Burns **Date registered:** 1 April 2005
Person in charge at the time of inspection: Ms Deirdre Burns	**Number of registered places:** 19
Categories of care: Residential Care (RC): MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years LD – learning disability LD(E) – learning disability – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 16
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 19 residents.	

2.0 Inspection summary

An unannounced inspection took place on 5 October 2021 from 10.30 am to 2.15 pm. The inspection was conducted by a pharmacist inspector and focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified since the last care inspection.

Review of medicines management found that residents were administered their medicines as prescribed. There were arrangements in place to ensure that staff were trained and competent in medicines management and the majority of medicine records were well maintained. Two areas for improvement regarding the cold storage of medicines and record keeping in relation to distressed reactions were identified.

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. We also spoke to 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

We met with one resident, a senior carer 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.

The resident said that it had taken them a while to settle into the home but that they now felt content. They said that they enjoyed living in the area.

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. Six questionnaires were returned from residents. All responses indicated that they were "very satisfied" with all aspects of care.

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 15 April 2021		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (7) **Stated:** Second time	The registered person shall ensure personal protective equipment is used appropriately by staff to prevent the spread of infection between residents and staff.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was in relation to the use of fluid resistant masks. All staff were observed to wear these masks appropriately during the 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 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.

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 and 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 verified and signed the personal medication records when they were written and updated to provide a check 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, self-administration 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 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. 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. Directions for use were recorded on the personal medication records and records of administration were clearly recorded. Staff were knowledgeable regarding why the medicines had been needed and what the outcome of each administration had been. However, care plans directing the use of the medicines were not in place and the reason for and outcome of each administration had not been recorded. An area for improvement was identified.

The management of pain was discussed. Regular pain relief was not prescribed for any residents. Staff advised that all residents were able to request pain relief if required.

Care plans were in place when residents required insulin to manage their diabetes. There was sufficient detail in the care plans to direct staff if the resident's blood sugar was too low/high.

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.

In relation to the cold storage of medicines, the minimum and maximum medicine refrigerator temperatures were recorded as 2^{o}C and 10^{o}C each day. To ensure that medicines are stored in accordance with the manufacturers' instructions, the refrigerator temperature must be maintained between 2°C and 8°C. The thermometer was reset during the inspection but temperatures remained outside the required range indicating that there may be a fault with the refrigerator or thermometer. An area for improvement was identified.

Discontinued/expired medicines were returned to the community pharmacy for disposal. A review of the disposal records indicated that the reason for disposal was not recorded and that the records had not been maintained in a bound book. The manager advised that a bound book would be brought into use from the date of the inspection onwards and that staff would be reminded to record the reason for each disposal.

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. The sample of these records reviewed were found to have been fully and accurately completed. The manager and senior carer were reminded that hand-written entries on the MARs should be verified and signed by two staff to ensure accuracy of transcribing. The records were filed once completed and were readily retrievable for audit/review.

Monthly audits on the management of medicines were completed. The audits completed at the inspection indicated that the majority of medicines had been administered as prescribed. A small number of discrepancies were discussed with the senior carer and manager for corrective action and close monitoring.

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 recently admitted residents or residents returning to the home following discharge from hospital was reviewed. There was evidence that robust arrangements were in place to ensure that written confirmation of the residents' current medicine regime was obtained and the GP and community pharmacy were contacted as necessary. Personal medication records had been accurately written. 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.

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 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 in relation to medicines management, diabetes, epilepsy awareness and buccal midazolam were available for inspection.

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 with respect to medicines management.

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 cold storage of medicines and the management of distressed reactions.

Although areas for improvement were identified, we can conclude that overall, with the exception of a small number of medicines, the residents were administered their medicines as prescribed by their GP.

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

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005 and the Residential Care Homes Minimum Standards (2011).

	Regulations	Standards
Total number of Areas for Improvement	1	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Deirdre Burns, 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 Residential Care Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall ensure that medicines requiring cold storage are stored between 2^{o}C and 8^{o}C. The thermometer must be reset each day and corrective action must be taken if temperatures outside this range are observed. Ref: 5.2.2
	Response by registered person detailing the actions taken: The fridge thermometer is now working correctly, repaired by an engineer with support from our local pharmacy. temperatures are recorded every moring and these are review regular by the manager.
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 6 **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall review the management of distressed reactions to ensure that care plans are in place, and the reason for and outcome of any administration are recorded. Ref: 5.2.1
	Response by registered person detailing the actions taken: Care plans are now in place to direct staff when to use, the reason for adminstration and the outcome is recorded.

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