Inspection Report

28 February 2023

Orchard Lodge Care Home

Type of service: Nursing Home
Address: Desart Lane South, Armagh, BT61 8BF
Telephone number: 028 3752 6462

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: Kathryn Homes Ltd **Responsible Individual:** Mr Stuart Johnstone	**Registered Manager:** Mrs Adelina Focseneanu (Registration pending)
Person in charge at the time of inspection: Mrs Adelina Focseneanu	**Number of registered places:** 55 This number includes a maximum of 40 patients in category NH-DE accommodated in the Orchard and Cathedral Units and a maximum of 15 patients in categories NH-I, NH-PH, NH-PH(E) accommodated in the Bard Unit.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia 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:** 46
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide nursing care for up to 55 patients. The home provides general nursing care and care to patients living with dementia. The home is divided into three units, one on the ground floor and two on the first floor. Patients' bedrooms, communal lounges and dining rooms are located over the two floors. An enclosed garden is accessed from the ground floor. A residential care home is also located on the ground floor. The same manager manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 28 February 2023, from 10.00am to 3.10pm. This was completed by a pharmacist inspector.

The inspection 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 robust arrangements were in place for the safe management of medicines. Medicines were stored safely and securely and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines.

The outcome of this inspection concluded that improvements in one area for the management of medicines is necessary. The new area for improvement regarding maintaining accurate personal medication records is detailed in the quality improvement plan.

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

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 with respect to medicines management.

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 care nursing staff, the deputy manager 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, 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 the last inspection?

Areas for improvement from the last finance inspection on 23 January 2023		
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)(c) **Stated:** First time	The registered person shall ensure that: • the reason for the use of bedrails is clearly recorded on bedrail risk assessments • the reason for the use of bedrails is clearly recorded on the bedrail audit tool • where bedrails are in use care plans should clearly reflect this, be kept under regular review and be rewritten as required. **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.**	**Carried forward to the next inspection**
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 4.9 **Stated:** Second time	The registered person shall ensure that wound care charts and wound evaluations are completed contemporaneously to reflect that the dressing has been changed as directed in the care plan. **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 4	The registered person shall ensure that the recommended frequency of repositioning is clearly recorded in relevant care plans and repositioning charts.	

Stated: First time	**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**

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.

It was identified that some of the personal medication records reviewed at the inspection were not up to date with the most recent prescription. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff did not use these records as part of the administration of medicines process. Obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the patient. An area for improvement was identified.

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 the management of 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. Records included the reason for and outcome of each administration.

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. Records of administration which included the recommended consistency level were maintained. However the personal medication record for two patients was not up to date with the most recent recommended consistency level. An area for improvement has already been identified regarding maintaining accurate personal medication records (see section 5.2.1).

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 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 monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

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. Most of the records reviewed were found to have been fully and accurately completed. The records were filed once completed.

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.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plans. Written consent and care plans were in place when this practice occurred.

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 all boxed 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.

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 incidents which had been reported to RQIA since the last inspection were discussed There was evidence that the incidents 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. However, audit discrepancies were observed in the administration of a small number of medicines. These 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 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. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	1*	3*

* 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 Mrs Adelina Focseneanu, 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 Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 12 (1)(a)(b)(c) **Stated:** First time **To be completed by:** With immediate effect (23 January 2023)	The registered person shall ensure that: • the reason for the use of bedrails is clearly recorded on bedrail risk assessments • the reason for the use of bedrails is clearly recorded on the bedrail audit tool • where bedrails are in use care plans should clearly reflect this, be kept under regular review and be rewritten as required.
	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
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for Improvement 1 **Ref:** Standard 4.9 **Stated:** Second time **To be completed by:** With immediate effect (23 January 2023)	The registered person shall ensure that wound care charts and wound evaluations are completed contemporaneously to reflect that the dressing has been changed as directed in the care plan.
	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 4 **Stated:** First time **To be completed by:** With immediate effect (23 January 2023)	The registered person shall ensure that the recommended frequency of repositioning is clearly recorded in relevant care plans and repositioning charts.
	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 29 **Stated:** First time	The registered person shall ensure that fully complete and accurate personal medication records are maintained and that obsolete records are cancelled and archived. Ref: 5.2.1
To be completed by: With immediate effect (28 February 2023)	**Response by registered person detailing the actions taken:** All medication records are maintained by Staff Nurses to ensure they reflect current medication regime. Home Manager and Deputy Manager complete monthly medication audits to monitor compliance. All Kardexs that have changes required are re-written, checked and coutersigned by a 2nd nurse. Discussed at Nurses meeting to ensure all Nurses are aware of importance of keeping medication records contemporous.

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