

# Inspection Report

**Name of Service:** Fairview & Craigdene Residential Care Home

**Provider:** Charline Care Homes Ltd

**Date of Inspection:** 19 November 2024

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

## 1.0 Service information

<b>Registered Provider:</b>	Charline Care Homes Ltd
<b>Responsible Person:</b>	Mr Gordon Graham Wilkinson
<b>Registered Manager:</b>	Mrs Gail Donnell
<b>Service Profile:</b> Fairview & Craigdene Residential Care Home is a residential care home registered to provide health and social care for up to 26 residents living with a learning disability. The home is divided into two buildings: Fairview and Craigdene, located on one site. Each can accommodate 13 residents.	

## 2.0 Inspection summary

An unannounced inspection took place on 19 November 2024, from 10.30am to 1.00pm. This was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care records were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. No new areas for improvement were identified.

Residents were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the residents well.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

RQIA would like to thank the staff for their assistance throughout the inspection.

### 3.0 The inspection

#### 3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from residents, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

#### 3.2 What people told us about the service and their quality of life

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after residents and meet their needs. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

RQIA did not receive any completed questionnaires or responses to the staff survey following the inspection.

### 3.3 Inspection findings

#### 3.3.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in residential care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times residents' needs may 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 or hospital appointments.

The personal medication records reviewed 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 confirm that they were accurate.

Copies of residents' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

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 etc.

The management of distressed reactions was reviewed. Residents will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care records are in place to direct staff 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. Directions for use were clearly recorded and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain and other factors. Records of administration included the reason for and outcome of each administration.

### **3.3.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?**

Medicine 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.

Records reviewed 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 medicine 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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage.

Satisfactory arrangements were in place for the safe disposal of medicines.

### **3.3.3 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.

A sample of the medicines administration records was reviewed. The records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

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.

### **3.3.4 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.

There had been no recent admissions/readmissions to the home. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the resident's medicines and this was shared with the GP and community pharmacist.

### **3.3.5 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. One audit discrepancy was highlighted to the manager for ongoing monitoring.

### 3.3.6 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 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.

## 4.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	0	7*

\* the total number of areas for improvement includes seven 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 Mrs Gail Donnell, Registered Manager, as part of the inspection process and can be found in the main body of the report.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022) (Version 1:2)</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Standard N10  <b>Stated:</b> Second time  <b>To be completed by:</b> From the date of inspection (24 April 2024)	The registered person shall provide a time bound action plan for the implementation of a call bell system for each bedroom.
	<p><b>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.</b></p> <p>Ref: 2.0</p>
<b>Area for improvement 2</b>  <b>Ref:</b> Standard 28.3  <b>Stated:</b> Second time  <b>To be completed by:</b> From the date of inspection (24 April 2024)	The registered person shall ensure that communal areas are assessed for hazards, to promote safe and healthy working practices relating specifically to: <ul style="list-style-type: none"> <li>• Accident prevention</li> <li>• Infection control</li> </ul>
	<p><b>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.</b></p> <p>Ref: 2.0</p>
<b>Area for improvement 3</b>  <b>Ref:</b> Standard 15.2  <b>Stated:</b> First time  <b>To be completed by:</b> 31 May 2023	The registered person shall ensure that the Health and Social Care Trust is contacted to request a review of the credit union accounts given a bank account for residents' monies is in operation. The review should include the accounts held for deceased residents and residents who no longer reside at the home.
	<p>The outcome of the review should be forwarded to RQIA once available.</p> <p><b>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.</b></p> <p>Ref: 2.0</p>

<p><b>Area for improvement 4</b></p> <p><b>Ref:</b> Standard 15.2</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 31 May 2023</p>	<p>The registered person shall ensure that the Health and Social Care Trust is contacted to request a review of the current arrangements for appointeeship of residents' benefits. The review should consider all options available for appointeeship and the agreed outcome should be in the best interests of the residents.</p> <p>The outcome of the review should be forwarded to RQIA once available.</p>
	<p><b>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.</b></p> <p>Ref: 2.0</p>
<p><b>Area for improvement 5</b></p> <p><b>Ref:</b> Standard 6.2</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 22 May 2024</p>	<p>The registered person shall ensure individual resident care plans are written with sufficient detail to direct the care required to meet the resident's needs. This is with regards to Deprivation of Liberty Safeguards.</p>
	<p><b>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.</b></p> <p>Ref: 2.0</p>
<p><b>Area for improvement 6</b></p> <p><b>Ref:</b> Standard 28</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> From the date of inspection (24 April 2024)</p>	<p>The registered person shall ensure that furniture in the identified rooms are maintained in a safe manner to reduce the risk of harm to residents.</p>
	<p><b>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.</b></p> <p>Ref: 2.0</p>
<p><b>Area for improvement 7</b></p> <p><b>Ref:</b> Standard 29.1</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 2 May 2024</p>	<p>The registered person shall ensure that the Fire Risk Assessment is reviewed within the timeframes recommended by the fire risk assessor.</p>
	<p><b>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.</b></p> <p>Ref: 2.0</p>



## The Regulation and Quality Improvement Authority

James House  
2-4 Cromac Avenue  
Gasworks  
Belfast  
BT7 2JA

---



**Tel:** 028 9536 1111



**Email:** [info@rqia.org.uk](mailto:info@rqia.org.uk)



**Web:** [www.rqia.org.uk](http://www.rqia.org.uk)



**Twitter:** @RQIANews