The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Granard**

Provider: **East Eden Ltd**

Date of Inspection: **17 February 2025**

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:	East Eden Ltd
Responsible Individual:	Dr Una McDonald
Registered Manager:	Ms Mai Devlin
Service Profile: Granard is a registered residential care home which provides health and social care for up to 26 residents. The home is divided into two units over two floors.	

2.0 Inspection summary

An unannounced inspection took place on 17 February 2025, from 10.25am to 3.15pm. This was completed by a pharmacist inspector and focused on medicines management within the home.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. 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 and residents were administered their medicines as prescribed. However, improvements were necessary in relation to cold storage, recording of dates of opening/commencement to facilitate audit and the self-administration of medicines.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, residents were being administered their medicines as prescribed.

Details of the inspection findings and areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

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.

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 registration information and any other written or verbal information received from residents, relatives, staff or the commissioning trust.

Throughout the inspection the RQIA inspector will seek to speak with residents, their relatives or visitors and staff to obtain their opinions on the quality of the care and support, their experiences of living, visiting or working in this home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

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.

Staff advised that they were familiar with how each resident liked to take their medicines. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

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 majority of 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. A small number of minor discrepancies were highlighted to the manager for immediate corrective action and on-going vigilance.

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, pain and insulin was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed at the inspection indicated that these medicines were administered as prescribed.

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. However, one inhaler was out of stock at the time of inspection, this resulted in several missed doses. The manager was aware of the out of stock and a prescription had been ordered from the GP. The inspector requested that the manager seek advice from the prescriber, investigate why the medicine was not available and submit an incident report to RQIA. An incident report was received following the inspection which included details of the actions taken to prevent recurrence. All other medicines were available on the day of the inspection.

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. The temperatures of the medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately.

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 maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. The temperature of the medicine refrigerator was

not monitored each day; this does not provide evidence that the temperature is maintained within the required range. An area for improvement was identified.

Satisfactory arrangements were in place for the storage of controlled drugs and 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. Most of the records were found to have been fully and accurately completed. A small number of discrepancies were brought to the attention of the manager for ongoing close monitoring. Records were filed once completed and were readily retrievable for audit/review.

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.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. However, the date of opening/commencement of new blister packs was not consistently recorded on medicines to facilitate audit and disposal at expiry. An area for improvement was identified.

Where residents self-administer their medication, it is important that the appropriate records are maintained. This includes records of the receipt of medication into the home and transfer to the resident. A care plan and risk assessment for self-administration should be in place. Any medicine which is transferred to a resident must be appropriately labelled to allow identification.

Where self-administration of medicine was taking place, care plans and risk assessments were in place, however records of transfer to the resident were not maintained and records of medicines administration did not accurately reflect that the resident was self-administering the medicines. The medicines were also not labelled to allow identification. This was discussed with the manager and an area for improvement was identified.

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines at the time of admission or for residents returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

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.

There had been no medicine related incidents reported to RQIA in the last two years. The inspector discussed the type of incidents which must be reported (including missed doses due to stock supply issues identified in Section 3.3.2) and signposted the manager to the RQIA provider guidance in relation to the statutory notification of medication related incidents available on the RQIA website.

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. The audits were discussed in detail with staff and the manager for on-going close vigilance.

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. Policies and procedures should be up to date and readily available for staff reference.

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.

It was agreed that the findings of this inspection would be discussed with staff to facilitate ongoing improvement.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Mai Devlin, 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 Homes Minimum Standards, December 2022	
Area for improvement 1 **Ref:** Standard 32 **Stated:** First time	The registered person shall ensure that maximum and minimum refrigerator temperatures are recorded daily to ensure medicines are stored between 2ºC and 8ºC. Ref: 3.3.2
To be completed by: 17 February 2025	**Response by registered person detailing the actions taken:** The temperature of the fridge has been recorded daily; however, the delivery of the new fridge has been delayed, with an estimated delivery time now set for week beginning April.
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time	The registered person shall ensure that the date of opening/commencement of blister packs is recorded on all medicines to facilitate audit and disposal at expiry. Ref: 3.3.3
To be completed by: 17 February 2025	**Response by registered person detailing the actions taken:** New blisters were initiated at the start of 24/03/2025, and if a new blister is commenced at a later date, staff are required to record the date it was commenced. This information was communicated during medication training on 18/03/2025 and through daily flash meetings. Additionally, the medication audit includes a requirement for staff to verify that any new blister packs initiated in the middle of a cycle are properly dated with the commencement date.
Area for improvement 3 **Ref:** Standard 33 **Stated:** First time	The registered person shall ensure that when medicines are transferred to residents for self-administration, records are accurately maintained and medicines are appropriately labelled. Ref: 3.3.3
To be completed by: 17 February 2025	**Response by registered person detailing the actions taken:** Medications for self-administration are now stored in individual jars, each clearly labelled, with a corresponding logbook available that records the date, time, medication name, strength, and is signed by both staff and the resident. This procedure was

	implemented effective from 21/02/2025. This is also highlighted on MARS sheet and key word used S= Self administration

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