The Regulation and Quality Improvement Authority

# Inspection Report

**Name of Service:** Glenkeen House

**Provider:** Hutchinson Homes Limited

**Date of Inspection:** 24 April 2025

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

## 1.0 Service information

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| **Organisation/Registered Provider:** | Hutchinson Homes Ltd |
| **Responsible Individual:** | Ms Naomi Carey |
| **Registered Manager:** | Mrs Jacqueline Elizabeth McShane |
| **Service Profile:**<br>Glenkeen House is a nursing home registered to provide nursing care for up to 40 patients. Patients' bedrooms are located over two floors. Patients have access to communal lounges, dining rooms and a garden. | |

## 2.0 Inspection summary

An unannounced inspection took place on 24 April 2025, from 10.05am to 3.10pm. The inspection 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.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were administered as prescribed and medicines were stored securely. Medicine records and most medicine related care plans were well maintained. However, improvements were necessary in relation to the management of medicines with a shortened expiry date once opened and the management of medicines prescribed for use 'when required' for distressed reactions.

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

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from patients, 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.

## 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 patients 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 patient 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?

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 a GP, a pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

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

All patients 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 pain, thickening agents and insulin were reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed.

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 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. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. Directions for use were recorded on the personal medication record and care plans were in place. The care plan should include the details of the medicines prescribed and the parameters for their use and the action to take if these medicines are required regularly. Records of administration included the reason for each administration. The outcome of each administration should also be routinely recorded. An area for improvement was identified.

### 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 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.

Records reviewed 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 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 patient 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 and the storage of controlled drugs. Staff were reminded to reset the refrigerator thermometer daily after recording temperatures.

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 patients to ensure that they are receiving the correct prescribed treatment.

A sample of the electronic medicines administration records was reviewed and found to have been accurately 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.

Management and staff audited the management and administration of medicines on a regular basis within the home and the audit system in use had recently been reviewed and updated. There was evidence that the findings of the audits had been discussed with staff and addressed. The date of opening was recorded on most medicines to facilitate audit and disposal at expiry. However, it was not included on all insulin pen devices or eye drops. These are medicines whose shelf lives shorten once opened and one expired insulin preparation was in use. An area for improvement was identified.

A review of the audits completed within the home indicated that the issues raised at this inspection had not been identified. It was agreed that these would be reviewed within the audit system.

### 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 patients 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.

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.

### 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 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. 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, annual competency assessments were due to be reviewed. The manager stated that these would be completed and added to the training matrix in the coming weeks. Medicines management policies and procedures were in place.

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

## 4.0 Quality Improvement Plan/Areas for Improvement

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

| | Regulations | Standards |
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| **Total number of Areas for Improvement** | 2* | 5* |

* the total number of areas for improvement includes five which were carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Jacqueline McShane, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

## Quality Improvement Plan

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| **Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005** | |
| **Area for improvement 1**<br><br>**Ref:** Regulation 13 (4)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>24 April 2025 | The registered person shall ensure that robust systems are in place to monitor the expiry dates of medicines and ensure that medicines are not administered after expiry.<br><br>Ref: 3.3.3 |
| | **Response by registered person detailing the actions taken:**<br>Expiry dates will be checked more consistently during audit and relevant action taken. |
| **Area for improvement 2**<br><br>**Ref:** Regulation 20 (1) (c) (i)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>28 February 2025 | The registered person shall ensure that all staff complete mandatory training on Mental Capacity Act - Deprivation of Liberty (DoL). |
| | **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.**<br><br>Ref: 2.0 |
| **Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022** | |
| **Area for improvement 1**<br><br>**Ref:** Standard 18<br><br>**Stated:** First time<br><br>**To be completed by:**<br>29 April 2024 | The registered person shall ensure that robust systems are in place for medicines prescribed for use 'when required', in the management of distressed reactions, to include:<br>• A person centred care plan, including the parameters for the administration of prescribed medicines<br>• A record of the effect of any medicines administered<br>• Regular use of these medicines being reported to the prescriber.<br><br>Ref: 3.3.1 |
| | **Response by registered person detailing the actions taken:**<br>A full review of all residents on "as required" medications for distressed reactions will be carried out. Person centred care plans will be implemented; medication records will include effect and regular review will be carried out. |
| **Area for improvement 2**<br><br>**Ref:** Standard 41<br><br>**Stated:** First time | The registered person shall ensure that the staff duty rota is maintained in keeping with legislation and best practice guidance. |
| | **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.** |

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| **To be completed by:**<br>21 February 2025 | Ref: 2.0 |
| **Area for improvement 3**<br><br>**Ref:** Standard 4<br><br>**Stated:** First time<br><br>**To be completed by:**<br>28 February 2025 | The registered person shall ensure patients care records contain a photograph of the patient where appropriate. |
| | **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.**<br><br>Ref: 2.0 |
| **Area for improvement 4**<br><br>**Ref:** Standard 37<br><br>**Stated:** First time<br><br>**To be completed by:**<br>21 February 2025 | The registered person shall ensure that any confidential information regarding patients' care needs is not kept in communal areas. |
| | **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.**<br><br>Ref: 2.0 |
| **Area for improvement 5**<br><br>**Ref:** Standard 35<br><br>**Stated:** First time<br><br>**To be completed by:**<br>28 February 2025 | The registered person shall ensure the weight loss audit evidences a clear time bound action plan to address / mitigate any further weight loss. |
| | **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.**<br><br>Ref: 2.0 |

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