The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Cairngrove

Provider: Cairnhill Home ‘A’ Ltd

Date of Inspection: 31 October 2024

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

1.0 Service information

Organisation:	Cairnhill Home 'A' Ltd
Responsible Individual:	Mr Charles Anthony Digney
Registered Manager:	Ms Hannah McComb
Service Profile: Cairngrove is a nursing home registered to provide nursing care for up to 23 patients with a learning disability. Patients' bedrooms are situated over two floors and patients have access to communal lounges, a dining room and gardens.	

2.0 Inspection summary

An unannounced inspection took place on 31 October 2024, from 10.20am to 15.30pm. 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. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. However, improvements were necessary in relation to the safe storage of thickeners, storage of insulin, the management of distressed reactions and auditing systems.

Whilst areas for improvement were identified, there was evidence that patients were being administered their medicines as prescribed.

Areas for improvement identified at the last care inspection will be reviewed at the next inspection. Full details of the inspection findings, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.0.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care. Patients were observed to be relaxed and comfortable and taking part in activities.

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

Patients spoken with told us that the home was "warm" and was "a nice place to live".

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.

No completed questionnaires or responses to the staff survey were received 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.

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.

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. Care plans directing the use of these medicines were in place for some, but not all, of the patients reviewed. Records of administration did not include the reason for and outcome of each administration. An area for improvement was identified.

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 were not in place for one patient who was reviewed; staff advised that the care plan would be written immediately following the inspection 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 and nutritional supplements were reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained. One patient's care record had not been updated with the current prescribed consistency level; this was addressed at the inspection.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside of the recommended range. One insulin pen device which was in use, had not been labelled with the patients' name and date of opening. This was discussed for immediate correction and ongoing vigilance.

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.

With the exception of two medicines prescribed for use 'when required', all medicines were available for administration as prescribed. Staff advised that doses had not been omitted as the medicines had not been required; assurances were provided that the medicines would be re-ordered. Staff advised that they had a good relationship with the community pharmacist and that medicines prescribed were supplied in a timely manner.

The medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was 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.

A significant number of unlabelled insulin pen devices were stored in the medicine refrigerator. Insulin pens should be individually labelled to denote ownership and to facilitate audit and disposal at expiry. An area for improvement was identified.

Eye drops were identified in the fridge which had exceeded their expiry date, these were highlighted to staff for disposal and ongoing monitoring.

With the exception of the out of date eye drops, 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 medicines administration records was reviewed. Most of the records were found to have been accurately completed. However, there were a small number of missed signatures for administration. In addition, not all hand-written updates on the pre-printed medication administration records had been verified and signed by two staff. It was agreed that this would be monitored through the home's audit processes. (see below). 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.

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. One patient's personal medication record had not been updated to indicate that medicines were being crushed and staff were unable to confirm that the prescriber had provided written authorisation; this was discussed for immediate corrective action.

The inspector observed afternoon drinks being prepared for patients and noted that a container of thickening agent was stored on top of the trolley whilst the staff member attended to patients who needed support with eating and drinking. Thickening agents must be safely stored at all times to prevent the potential for accidental ingestion. An area for improvement was identified.

The audits completed by management and staff had not identified the issues identified at this inspection. A robust audit system should be implemented which covers all aspects of the management and administration of medicines including those identified. Any shortfalls identified should be detailed in an action plan and addressed. 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 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.

One medicine related incident had been reported to RQIA since the last inspection. This was discussed. The deputy manager advised that staff were aware of the types of incidents which require reporting to RQIA.

The audits trails completed at the inspection indicated that medicines were being administered as prescribed.

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 and deemed competent. Ongoing review was monitored through supervision 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 the necessary improvement.

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
Total number of Areas for Improvement	4*	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 the nurse in charge and Mr Charles Anthony Digney, Responsible Individual 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 Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 31 October 2024	The registered person shall ensure that insulin pens are labelled to denote ownership and to facilitate audit and disposal at expiry. Ref: 3.3.2
	Response by registered person detailing the actions taken: All insulin pens have been clearly labelled to denote ownership and to facilitate audit and disposal at expiry, and have been left in their original box.
Area for improvement 2 **Ref:** Regulation 20 (1) (c) (l) **Stated:** First time **To be completed by:** 4 August 2023	The registered person shall ensure all staff receive training in the Deprivation of Liberty – Level 2.
	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: 2.0
Area for improvement 3 **Ref:** Regulation 27 (1) (c) **Stated:** First time **To be completed by:** 4 August 2023	The registered person shall make good the identified items of furniture and equipment so these can be in keeping for effective cleaning.
	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: 2.0
Area for improvement 4 **Ref:** Regulation 27 (2) (t) **Stated:** First time **To be completed by:** 11 July 2023	The registered person shall risk assess the width of window openings in accordance with current safety guidance with subsequent appropriate action.
	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: 2.0

Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 18.9 **Stated:** First time **To be completed by:** 31 October 2024	The registered person shall ensure that care plans are in place where medication is prescribed for the management of distressed reactions, and that the reason and outcome are recorded for each administration. Ref: 3.3.1
	Response by registered person detailing the actions taken: individual resident care plans have been examined and where appropriate updated to ensure that any medication prescribed for the management of distressed reactions gives explanation for the use of the medication and any outcomes are all recorded.
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** With immediate effect (31 October 2024)	The registered person shall ensure that thickening agents are safely and securely stored. Ref: 3.3.3
	Response by registered person detailing the actions taken: Procedure has been put in place to ensure thickening agents have been put in place; thickening agents are stored in a locked cupboard and only taken out under the supervision of staff member and to be used at that time. This is under regular auditing to ensure staff adhere to new measures.
Area for improvement 3 **Ref:** Standard 28.10 **Stated:** First time **To be completed by:** 31 October 2024	The registered person shall implement a robust audit system which covers all aspects of the management and administration of medicines including those identified at this inspection. Any shortfalls identified should be detailed in an action plan and addressed. Ref: 3.3.3
	Response by registered person detailing the actions taken: Since the inspection in October, we have initated the medicine management audit tool that was suggested at inspection. This should identify a broader range of potential issues and allow them to be addressed in a more timely fashion..

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