

# Inspection Report

**Name of Service: Orchard Grove**

**Provider: Orchard Grove Residential Care Home LLP**

**Date of Inspection: 28 November 2024**

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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| <b>Organisation/Registered Provider:</b>  | Orchard Grove Residential Care Home<br>LLP |
| <b>Responsible Individual:</b>  | Mr Mark Craig Emerson                      |
| <b>Registered Manager:</b>  | Ms Deirdre Burns                           |
| <p>Orchard Grove is a registered residential care home which provides health and social care for up to 19 residents under and over 65 years of age, living with a learning disability or a mental disorder excluding learning disability or dementia.</p> <p>The home is divided over two floors. All residents have access to communal bathrooms, the lounge, a large dining room and the garden area.</p> <p>There is a day centre which occupies one room in the home. The registered manager for this home manages both services.</p> |  |

## 2.0 Inspection summary

An unannounced inspection took place on 28 November 2024, from 10.20am to 12.20pm. 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.

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 plans were well maintained. There were effective auditing processes in place to ensure that staff were trained to manage medicines and residents were administered their medicines as prescribed.

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

Details of the inspection findings can be found in the main body of this report; no areas for improvement were identified.

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 process, inspectors seek the views of those 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 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 and medicines were administered in accordance with individual resident preference, needs and timing requirements.

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?**

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. A small number of minor discrepancies were highlighted to staff 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 pain and insulin was 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.

Some residents 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 resident 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 resident.

The management of thickening agents was reviewed. Speech and language assessment reports and care plans were in place. Staff were familiar with each resident's recommended consistency level and records of administration were maintained. However, the recommended consistency level was not recorded on some prescribing and administration records; this was discussed with the manager who agreed to update the records immediately and monitor through the home's audit process.

### **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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located. Satisfactory arrangements were in place for medicines requiring cold storage. The maximum, minimum and current temperatures of medicine refrigerator were monitored and recorded each day. The manager advised that the refrigerator thermometer was reset each day and that the treatment room temperature was also monitored each day. The manager was reminded that a record should be maintained of the room temperature and resetting the refrigerator thermometer.

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. Records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

It is important that staff follow safe medication administration processes to ensure that medicines are administered to the right resident at the right time and the appropriate records are maintained. This includes administering medicines to each resident directly from their dispensed supply and signing the record of administration immediately after the medicine has been administered to the specific resident.

Management and staff audited the administration of medicines on a regular basis within the home. The date of opening was recorded on medicines to facilitate audit and disposal at expiry. Records of these audit trails were available for inspection. The medicines management tool (available on RQIA website) was shared with the manager to aid the expansion of audits to cover all areas of medicines management.

### **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 has been no medicine related incidents reported to RQIA since the last medicines management inspection. Management and staff were familiar with the type of incidents that should be reported. The inspector signposted staff to the 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 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 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. Medicines management policies and procedures were in place.

## 4.0 Quality Improvement Plan/Areas for Improvement

|  | Regulations | Standards |
|--|-------------|-----------|
| <b>Total number of Areas for Improvement</b> | 0           | 0         |

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Deirdre Burns, Registered Manager, as part of the inspection process and can be found in the main body of the report.



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