The Regulation and Quality Improvement Authority

Inspection Report

23 April 2021

Lecale Lodge

Type of service: Residential Care Home
Address: 26 Strangford Road, Downpatrick, BT30 6SL
Telephone number: 028 4461 6487

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: Four Seasons Health Care **Responsible Individual:** Ms Natasha Southall, registration pending	**Registered Manager:** Ms Rita Denvir, registration pending
Person in charge at the time of inspection: Ms Rita Denvir, Manager	**Number of registered places:** 15 This number includes a maximum of 11 residents in category RC-MP/MP(E) and a maximum of four residents in category RC-I.
Categories of care: Residential Care (RC): I - old age not falling within any other category MP - mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia - over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 11
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 15 residents. The home is situated in the same building as Lecale Lodge nursing home.	

2.0 Inspection summary

An unannounced inspection took place on 23 April 2021 from 10.30am to 1.10pm. The inspection was completed by a pharmacist inspector.

This inspection focused on medicines management within the home. The inspection also assessed progress with any areas for improvement identified at the last care inspection.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing 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 previous inspection findings, incidents and correspondence.

To complete the inspection: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines, were reviewed.

During the inspection the inspector:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

4.0 What people told us about the service

The inspector met with the team leader and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff were warm and friendly and it was evident from their interactions that they knew the residents well.

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 spoke highly of the support given by management and the communication within the home.

In order to reduce the footfall throughout the home, the inspector did not meet with any residents during the inspection. However, feedback methods included a staff poster and paper questionnaires which were provided to the manager for any resident or their representative to complete and return using pre-paid, self-addressed envelopes.

At the time of issuing this report no questionnaires had been returned from residents/ their representatives.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

Areas for improvement from the last care inspection on 4 February 2021		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall review the process for the administration of medicines to ensure that staff witness the administration. Records of administration should be completed following administration.	**Met**
	Action taken as confirmed during the inspection: This was discussed with the manager and team leader who provided assurances that staff remained with each resident until they had taken their prescribed medicines and that records of administration were then completed.	
Area for Improvement 2 **Ref:** Regulation 14 (2) (a) **Stated:** First time	The registered person shall ensure in relation to health and welfare, that wet floors in the home are signed at all times in order to prevent a slip hazard.	**Met**
	Action taken as confirmed during the inspection: The team leader advised that this procedure was followed. We observed signage to be in place for wet floors to prevent a trip hazard.	

5.2 Inspection findings

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

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

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 e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection 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 provide a double check that they are accurate.

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

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.

Residents 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 on 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 the management of distressed reactions was reviewed. Directions for use were clearly recorded on the personal medication records and records of administration were maintained. The reason for and outcome of administration were recorded. Staff on duty knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour and were aware that this change may be associated with pain. However, care plans did not provide sufficient detail to direct the use of these medicines. The care plans were updated during the inspection.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required.

A small number of residents self-administer their inhalers. Staff advised that they give the residents the inhalers at the start of each four week medicine cycle which enables them to monitor compliance. This had not been recorded on the personal medication records or medication administration records and care plans were not in place. This was addressed during the inspection and it was agreed that a record of the transfer of the inhalers to the residents would be maintained from the date of the inspection onwards.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time?

Medicines 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.

The records inspected 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 medicines 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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

The disposal arrangements for medicines were reviewed. Discontinued medicines were returned to the community pharmacy for disposal and records maintained.

5.2.3 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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. These records were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for review/audit.

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 were recorded appropriately in controlled drug record books.

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 all medicines so that they could be easily audited. This is good practice.

The audits completed during this inspection showed that residents had been given their medicines as prescribed. One audit discrepancy for an inhaled medicine was observed. This was discussed with the manager and team leader for ongoing close monitoring.

5.2.4 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 to the home. Records for recent re-admissions (from hospital) to the home were reviewed. Robust arrangements were in place to ensure that staff were provided with a list of prescribed medicines and this was shared with the GP and community pharmacist. Medicines had been accurately received into the home and administered in accordance with the most recent directions. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

The medicine cups used to administer medicines to residents were labelled as single use. Therefore, they should be discarded after each use. However, the team leader advised that the cups are washed after use and then reused. This matter was discussed with the manager who gave an assurance that the necessary arrangements would be made to ensure that this practice is stopped.

5.2.5 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.

The audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported.

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 learning shared with staff in order to prevent a recurrence.

5.2.6 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 staff are competent in managing medicines and that staff are supported. Policies and procedures should be up to date and readily available for staff use.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments. Records of staff training in relation to medicines management were available for inspection.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led regarding the management of medicines.

The outcome of this inspection concluded that all areas for improvement identified at the last inspection had been addressed. No new areas for improvement were identified.

We can conclude that overall, the residents were being administered their medicines as prescribed. Based on the inspection findings and discussions held, we are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the manager/management team regarding the management of medicines.

We would like to thank the residents and staff for their assistance throughout the inspection.

7.0 Quality Improvement Plan/Areas for Improvement

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

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