Inspection Report

12 May 2022

Newcroft Lodge

Type of service: Residential Care Home
Address: 126 Church Road, Holywood, BT18 9BY
Telephone number: 028 9042 4614

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: South Eastern Health and Social Care Trust **Responsible Individual:** Ms Roisin Coulter	**Registered Manager:** Mr Samuel David McMahon **Date registered:** 1 April 2005
Person in charge at the time of inspection: Mr Samuel McMahon	**Number of registered places:** 32
Categories of care: Residential Care (RC): DE – dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 23
Brief description of the accommodation/how the service operates: Newcroft Lodge is a residential care home which is registered to provide care for up to 32 residents who are living with dementia.	

2.0 Inspection summary

An unannounced inspection took place on 12 May 2022 from 10.10am to 1.50pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

Following discussion with the aligned care inspector, it was agreed that any areas for improvement identified at the last care inspection would be followed up at the next care inspection.

Review of medicines management found that residents were being administered their medicines as prescribed. There were arrangements for auditing medicines and the majority of medicine records were well maintained. Arrangements were in place to ensure that senior carers were trained and competent in medicines management. One area for improvement was identified in relation to the management of medicine dosage changes.

RQIA would like to thank the residents, staff and management for their assistance throughout the inspection.

3.0 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 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 the following were reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke with staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

Residents were observed to be relaxing throughout the home. Staff were warm and friendly and it was evident from discussions that they knew the residents well. Staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The inspector met with the senior carer and the manager. The senior carer expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, one questionnaire had been returned to RQIA by a relative. Their response indicated that they were "very satisfied" with all aspects of the care provided in the home.

5.0 The inspection

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

The last inspection undertaken was a care inspection (25 March 2022). The report has been delayed and this was discussed at the inspection.

5.2 Inspection findings

5.2.1 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 the personal medication records reviewed at the inspection were accurate and up to date. In line with safe practice, a second senior carer had checked and signed the personal medication records when they were written. However, a small number of medication changes had not been recorded appropriately. Entries on the personal medication records and pre-printed medication administration records had been amended rather than discontinued and a new entry made. This could result in the wrong dose being administered and made it difficult to determine when the new dosage directions started. When a new dose has been prescribed, a new entry should be recorded on the personal medication record and medication administration record. A line should be drawn though the obsolete label on the medicine container so that staff refer to the personal medication record for the current dosage directions. An area for improvement was identified.

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 was reviewed for two residents. The senior carer advised that all staff were familiar with how each resident expressed their pain and that pain relief was administered when required. Regular pain assessments were carried out by the senior care staff. It was agreed that the care plan for one resident would be further updated following the inspection.

Staff were knowledgeable regarding the management of medicines prescribed on a "when required" basis for distressed reactions. These medicines were not currently prescribed for any residents.

The time of administration of medicines which assist sleep was discussed with senior staff and the manager. They were knowledgeable regarding each resident's individual needs.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

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. The medicine refrigerator and controlled drug cabinet were being used appropriately.

Appropriate arrangements were in place for the disposal of medicines.

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. The records had been completed in a satisfactory manner. A small number of missed signatures were highlighted to the manager for ongoing close monitoring. See also Section 5.2.1, regarding the management of medication changes.

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 in the controlled drug record book. The records reviewed had been maintained to the required standard.

Management and staff audited medicine administration on a monthly basis within the home. The findings were discussed with staff individually and at team meetings.

The audits completed at the inspection indicated that the majority of medicines had been administered as prescribed. A number of minor discrepancies in the administration of medicines, where the dosage directions had recently changed, were discussed with the senior carer and manager for ongoing close monitoring (See Section 5.2.1).

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.

The management of medicines for residents who were recently admitted to the home was reviewed. There was evidence that written confirmation of their prescribed medicines had been received (from hospital discharge letter/GPs) prior to admission. Personal medication records and medication administration records had been verified and signed by two senior carers to ensure accuracy. The audits completed at the inspection showed that the medicines had been administered as prescribed.

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 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 who manage and administer medicines are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available.

There was evidence that senior carers had received a structured induction which included medicines management. Update training on the management of medicines and competency assessments were completed annually. Records were available for inspection.

The South Eastern Health and Social Care Trust medication policies and procedures were available for staff reference.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005.

	Regulations	Standards
Total number of Areas for Improvement	1	0

The area for improvement and details of the Quality Improvement Plan was discussed with Mr Samuel McMahon, 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 Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that robust systems are in place for the management of medication dosage changes. Ref. 5.2.1 & 5.2.3
	Response by registered person detailing the actions taken: The registered manager can confirm that robust systems have been put in place in the home for the management of medication dosage changes; and will be reinforced in the forthcoming staff meeting. This will also be reviewed in future audits to ensure compliance.

Please ensure this document is completed in full and returned via the Web Portal

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews