

Inspection Report

12 and 23 August 2022



Northwick House

Type of service: Residential Care Home
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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Northwick House Responsible Individuals: Mrs Carole Helena Johnston Mrs Dorothy Elizabeth Hannah Johnston	Registered Manager: Mrs Carole Helena Johnston Date registered: 1 April 2005
Person in charge at the time of inspection: Mrs Dorothy Elizabeth Hannah Johnston	Number of registered places: 15 This number includes a maximum of 5 residents in category RC-DE and a maximum of 2 residents in categories RC-LD or RC-LD (E).
Categories of care: Residential Care (RC): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia LD – learning disability LD(E) – learning disability – over 65 years PH(E) - physical disability other than sensory impairment – over 65 years	Number of residents accommodated in the residential care home on the day of this inspection: 14
Brief description of the accommodation/how the service operates: Northwick House is a registered residential care home which provides social care for up to 15 persons. Resident bedrooms are located over two floors. Residents have access to communal lounges, dining rooms and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 12 August 2022, from 10.00am to 2.00pm and on 23 August 2022 from 11.00am to 1.45pm. The inspection was completed by a pharmacist inspector and a finance inspector.

The inspection focused on medicines management and the management of residents' finances 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 and the management of residents' finances.

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

Review of medicines management found that medicine records and medicine related care plans were well maintained. Medicines were stored safely and securely and there were processes in place to ensure staff were trained and competent to manage medicines. One new area for improvement was identified in relation to expanding the current medicines audit activity.

Whilst one new area for improvement was identified, RQIA can conclude that overall, with the exception of a small number of medicines, the residents were being administered their medicines as prescribed.

With regards to finance, adequate controls surrounding residents' finances were in place. Residents' financial records were up to date at the time of the inspection. No new areas for improvement were identified.

RQIA would like to thank the staff 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 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. The inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. A sample of residents' financial files which included records of transactions and residents' personal property was also reviewed.

Staff views were also obtained.

4.0 What people told us about the service

The inspector met with senior care staff and the responsible person. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs. Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well.

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, no questionnaires had been received by RQIA.

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 24 November 2021		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for Improvement 1 Ref: Regulation 27 (4) (b) Stated: First time	The registered person shall ensure that all fire doors are fully closing.	Carried forward to the next inspection
	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.	
Action required to ensure compliance with Residential Care Homes Minimum Standards (2021)		Validation of compliance
Area for Improvement 1 Ref: Standard 6.2 Stated: First time	The registered person shall ensure that care plans accurately reflect the needs of the residents and are reviewed on a regular basis.	Carried forward to the next inspection
	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.	

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 may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, the 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 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 state that they were accurate. A number of obsolete personal medication records remained in the medicines file. Staff were reminded that these should be suitably archived to ensure obsolete directions are not referred to. Assurances were provided that this would be actioned immediately following the inspection.

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.

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 care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain. Records included the reason for and outcome of each administration.

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. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the safe 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.

A sample of the medicines administration records was reviewed. The records reviewed were found to have been fully and accurately completed. The records were filed once 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 medicine administration within the home. Audits included monthly stock audits and daily running stock balances. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a number of medicines including inhaled and oral medicines. A review of the monthly management medicine audits indicated that the issues raised at this inspection were not being identified and needs to be expanded. An area for improvement was identified.

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 one new resident who was discharged from hospital to the home was reviewed. A review of records indicated that satisfactory arrangements were in place. A hospital discharge letter had been received and a copy had been forwarded to the resident's GP. The medicine records had been accurately completed. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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.

There have been no medicine related incidents reported to RQIA. As stated in Section 5.2.3, the current medicines audit process requires expansion to ensure medicine related incidents are effectively identified. A robust audit system which covers all aspects of medicines management is necessary to ensure that safe systems are in place and medicines are administered as prescribed.

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 they are supported.

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 sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

5.2.7 What arrangements are in place to ensure that residents' monies, valuables and personal property are appropriately managed and safeguarded?

A safe place was provided within the home for the retention of residents' monies and valuables. At the time of the inspection there were satisfactory controls around the physical location of the safe place and the members of staff with access to it. Records of residents' monies held at the home were up to date at the time of the inspection. Discussion with staff and a review of the safe place confirmed that no valuables were held on behalf of residents.

Discussion with staff confirmed that no bank accounts were managed on behalf of residents and no comfort fund monies were held, these are monies donated to the home for the benefit of all residents.

A sample of records evidenced that reconciliations (checks) of monies held on behalf of residents were undertaken on a weekly basis. The records of the reconciliations were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.

Three residents' finance files were reviewed; copies of written agreements were retained in all three files. The agreements included the details of the current weekly fee paid by, or on behalf of, the residents and a list of services provided to residents as part of their weekly fee. A list of services available to residents at an additional cost, such as hairdressing, was also included. The agreements were signed by the resident, or their representative, and a representative from the home.

In line with good practice signed authorisation forms for holding residents' monies and undertaking purchases on behalf of residents were also included in the agreements. Good practice was also observed as a sample signature of the hairdresser was retained within the files to facilitate the audit process.

A sample of records of fees received for two residents evidenced that the amounts received were in line with the amounts owed by the residents. Discussion with staff confirmed that no resident was paying an additional amount towards their fee over and above the amount agreed with the health and social care trusts.

Discussion with staff confirmed that no member of staff was an appointee for any resident, namely a person authorised by the Department for Communities to receive and manage the social security benefits on behalf of an individual.

A sample of purchases undertaken on behalf of residents was reviewed. The records were up to date at the time of the inspection. Two signatures were recorded against each entry in the residents' records and receipts were available from each of the purchases reviewed. In line with good practice a list of sample signatures of members of staff authorised to undertake transactions, on behalf of residents, was retained within the finance files.

A sample of records of payments to the hairdresser and podiatrist was reviewed. These records were up to date and signed by the hairdresser and podiatrist. The records were countersigned by a member of staff to confirm that the treatments took place.

A sample of records of monies deposited at the home on behalf of a resident was reviewed. Records were up to date at the time of the inspection. Receipts were provided to the person depositing the monies on behalf of the resident.

A sample of three residents' files evidenced that property records were in place for all three residents. The records were updated with additional items brought into residents' rooms and when items were disposed of. The records were checked and signed by two members of staff at least quarterly.

Policies and procedures for the management and control of residents' finances were available for inspection. The policies were readily available for staff use. The policies were up to date and reviewed at least every three years.

Discussion with staff confirmed that no transport scheme was in place at the time of the inspection.

No areas for improvement were identified during the finance inspection.

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 Minimum Standards 2021.

	Regulations	Standards
Total number of Areas for Improvement	1*	2*

* The total number of areas for improvement includes two which are carried forward for review at the next inspection.

The area for improvement and details of the Quality Improvement Plan were discussed with Mrs Dorothy Johnston, Responsible Person and Mrs Jackie Nicholl, Senior Carer, as part of the inspection process. The timescale for completion commences 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 27 (4) (b) Stated: First time To be completed by: Immediate and ongoing (24 November 2021)	The registered person shall ensure that all fire doors are fully closing.
	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: 5.1
Action required to ensure compliance with Residential Care Homes Minimum Standards 2021	
Area for improvement 1 Ref: Standard 6.2 Stated: First time To be completed by: Immediate and ongoing (24 November 2021)	The registered person shall ensure that care plans accurately reflect the needs of the residents and are reviewed on a regular basis. Ref: 5.1
	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.
Area for improvement 2 Ref: Standard 30 Stated: First time To be completed by: 2 September 2022	The responsible person shall implement a robust audit system which covers all aspects of the management of medicines. Any shortfalls identified should be detailed in an action plan and addressed. Ref: 5.2.3 & 5.2.5
	Response by registered person detailing the actions taken: Additional auditing procedures as well as those carried out monthly have been put into place. This includes all forms of medication.

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