Inspection Report
16 December 2020

Rosedale

Type of Home: Residential Care Home
Address: 100 Kilgreel Road, Antrim BT41 1EH
Tel No: 028 9442 9402
Inspector: Helen Daly

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a residential care home which is registered to provide care for up to 38 residents. The home provides care for short term periods of recovery and rehabilitation following hospital stays before residents return home or move onwards to a more permanent care placement. The home also provides periods of respite care.

2.0 Service details

Organisation/Registered Provider: Northern HSC Trust **Responsible Individual:** Ms Jennifer Welsh, Acting	**Registered Manager and date registered:** Ms Angela Denvir, Acting
Person in charge at the time of inspection: Ms Geraldine Lyndsey, Senior Carer	**Number of registered places:** 38
Categories of care: Residential Care (RC): I – old age not falling within any other category	**Total number of residents in the residential care home on the day of this inspection:** 7

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 16 December 2020 from 12.00 to 14.10.

This inspection focused on medicines management within the home. It also assessed progress with any areas for improvement identified during and since the last care and medicines management inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- 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

A sample of the following was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drug records
- care plans related to medicines management
- governance and audit records
- staff training and competency records
- medicine storage temperatures

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	2*

*The total number of areas for improvement includes one that has been stated for a second time under the Standards.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Geraldine Lyndsey, Senior Carer, and Ms Angela Denvir, Manager, as part of the inspection process. The timescales commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

5.0 What has this home done to meet any areas for improvement identified at the last medicines management inspection (23 February 2018) and last care inspection (28 February 2020)?

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 30 **Stated:** First time	The registered person shall develop a monitoring process for antibiotic medicines to ensure that these are administered as prescribed.	**Met**
	Action taken as confirmed during the inspection: Running stock balances were maintained for antibiotic medicines. We reviewed two recently prescribed antibiotics. They had been administered as prescribed.	
Area for improvement 2 **Ref:** Standard 6 **Stated:** First time	The registered person shall review the management of distressed reactions to ensure that details of the reason for and outcome of any administration are recorded on each occasion.	**Met**
	Action taken as confirmed during the inspection: We reviewed the management of distressed reactions for one resident. The reason for and outcome of administration had been recorded on most occasions. The senior carer advised that this would continue to be closely monitored to ensure ongoing compliance.	
Area for improvement 3 **Ref:** Standard 31 **Stated:** First time	The registered person shall ensure that medicines administration records in relation to external preparations are fully maintained.	**Not met**
	Action taken as confirmed during the inspection: Records of administration for external preparations were not maintained. **This area for improvement is stated for a second time.**	

Areas for improvement from the last care inspection		
Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that the following issues in relation to accidents/incidents are addressed: • Accidents/incidents entered in the Trust Datix system should be reviewed to identify any that should have been submitted to RQIA in accordance with RQIA's Statutory Notification of Incidents and Deaths guidance document dated September 2017. A retrospective notification should be submitted for any accidents/incidents not previously notified to RQIA. • RQIA's Statutory Notification of Incidents and Deaths guidance document should be shared with all staff responsible for submitting notifications to ensure compliance with the timescale set out in the regulations.	**Met**
	Action taken as confirmed during the inspection: A review of the accidents/incidents which had been submitted to RQIA following the last inspection indicated that the identified notifications had been reported to RQIA retrospectively. The manager advised that RQIA's Statutory Notification of Incidents and Deaths guidance document had been shared with all senior care staff to ensure compliance with the timescale set out in the regulations. There was evidence that notifiable incidents had been reported to RQIA within the timescale set out in the regulations.	

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 23.3 **Stated:** First time	The registered person shall ensure that mandatory training requirements are met.	**Met**
	Action taken as confirmed during the inspection: The majority of mandatory training was available online. All staff members had an email address to ensure that they had access to the training. A training matrix was in place. It was maintained by a senior carer and reviewed regularly by the manager to ensure ongoing compliance.	
Area for improvement 2 **Ref:** Standard 25.8 **Stated:** First time	The registered person shall ensure that staff meetings are held on a regular basis and at least quarterly.	**Met**
	Action taken as confirmed during the inspection: There was evidence that staff meetings had taken place in February and June 2020. Due to Covid 19 and the requirement for social distancing it was not possible to hold staff meetings. The manager advised that when social distancing restrictions are stepped down the quarterly meetings will resume. In the meantime, information (including learning alerts, policy changes, infection prevention and control protocols, Covid updates and staff support services) were shared with all staff through daily team briefings. The information was printed and staff signed to confirm that they had read and understood. From November 2020 onwards the Trust issued monthly core briefs to facilitate sharing of information. These briefs continue to take place each morning, afternoon and evening to ensure that all staff are included. Due to these assurances this area for improvement was assessed as met.	

6.0 What people told us about this home?

In order to reduce footfall in the home, we did not walk throughout the home or meet with any residents.

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

We met with two senior care assistants during the inspection and spoke to the manager via telephone call, following the inspection. 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 also said that they had the appropriate training to look after residents and meet their needs. Comments made included:

- "There is a great atmosphere. We work well together. The residents are well looked after. I would let a family member stay here."
- "It's a great home."

Feedback methods included a staff poster and paper questionnaires which were provided to the senior carer in charge 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.

7.0 Inspection Findings

7.1 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 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 were admitted to Rosedale from hospital for a period of rehabilitation. Each resident was provided with a 28 day supply of their medicines on discharge from hospital and registered temporarily with a local GP. Acute and newly prescribed 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. at medication reviews, hospital appointments.

The majority of 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 to check that they were accurate. However, the following improvements were necessary:

- all updates on the personal medication records should be verified and signed by two staff to ensure accuracy
- when prescribed, oxygen should be recorded on the personal medication records
- when a medicine is self-administered this should be clearly recorded

An area for improvement was identified.

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, self-administration etc.

Bridging care plans developed by the health care professional who organised the admission were in place. The bridging care plans and care notes were observed to have been updated by Rosedale staff when there were changes to the planned care.

The management of pain was discussed. Bridging care plans were in place and staff advised that all residents could tell them when they were in pain and that additional pain relief was administered when required.

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. We reviewed the management of thickening agents for one resident. 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. Staff advised that they had received training on the management of thickening agents.

7.2 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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

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

7.3 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.

The sample of medication administration records reviewed had been accurately maintained. However, as identified at the last medicines management inspection, records of administration of external preparations were not maintained. An area for improvement was stated for a second time.

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 a controlled drug record book.

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 medicines had been given as prescribed.

7.4 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.

We reviewed the management of medicines on admission and discharge for residents and found that robust systems were in place. Each resident was admitted to the home with a 28 day supply of their medicines and a hospital discharge letter. The discharge letter was held in the medicines file and a copy was forwarded to their temporary GP. The residents' personal medication records had been verified and checked by two trained staff to ensure accuracy. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

The senior carers advised that a community discharge facilitator co-ordinates each discharge from the home. Staff ensured that accurate medication discharge information is given to the resident and provided for their GP. There were systems in place to ensure that the resident was supplied with sufficient medication to last until they obtained a new supply from their GP.

7.5 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.

7.6 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.

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.

8.0 Evaluation of Inspection

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

The outcome of this inspection concluded that one area for improvement identified at the last medicines management inspection had not been addressed. One new area for improvement was identified.

Whilst we identified areas for improvement, we can conclude that overall the residents were being administered their medicines as prescribed by their GP.

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

9.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Geraldine Lyndsey, Senior Carer, and Ms Angela Denvir, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

9.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

9.2 Actions to be taken by the home

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)

Area for improvement 1 **Ref**: Standard 31 **Stated:** Second time **To be completed by:** From the date of inspection onwards	The registered person shall ensure that medicines administration records in relation to external preparations are fully maintained. Ref: 5.0 and 7.3
	Response by registered person detailing the actions taken: Senior Care staff and care staff instruted in line with Medication Policy to have appendix 3 recording sheet in service users room to ensure accurate recording of application of creams and emolients. This has been implemented and maintained for all service users external preparations.
Area for improvement 2 **Ref**: Standard 31 **Stated:** First time **To be completed by:** From the date of inspection onwards	The registered person shall ensure that: • all updates on the personal medication records are verified and signed by two staff to ensure accuracy • when prescribed, oxygen is recorded on the personal medication records • when a medicine is self-administered this is clearly recorded Ref: 7.1
	Response by registered person detailing the actions taken: All kardex sheets audited to ensure compliance with medication policy that all updates are checked and verified by two senior care staff. Oxygen prescribed has been included and recorded on personal kardex. Senior Care staff have been reminded to follow protocol in line with medication policy to record when a service user is self-administering medication.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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

Assurance, Challenge and Improvement in Health and Social Care