The Regulation and Quality Improvement Authority

Inspection Report

18 November 2022

Castle Lodge Care Home

Type of service: Residential Care Home
Address: 7-9 Fennel Road, Antrim, BT41 4PB
Telephone number: 028 9442 8212

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Healthcare Ireland No 2 Ltd **Responsible Individual:** Ms Amanda Mitchell	**Registered Manager:** Mrs Una Brady **Date registered:** 5 August 2010
Person in charge at the time of inspection: Mrs Una Brady	**Number of registered places:** 39 There shall be a maximum of 14 residents accommodated within category of care RC-DE and located in the Dementia Unit, Ground Floor.
Categories of care: Residential Care (RC) DE – dementia I – old age not falling within any other category	**Number of residents accommodated in the residential care home on the day of this inspection:** 36
Brief description of the accommodation/how the service operates: This home is a registered residential care home which provides health and social care for up to 39 residents. The home is divided over two floors including a dementia unit located on the ground floor. Residents have access to communal lounges, dining rooms and garden space.	

2.0 Inspection summary

An unannounced inspection took place on 18 November 2022, from 10.15am to 1.45pm. This 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 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 robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed.

Based on the inspection findings and discussions held, RQIA 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 management team with respect to medicines management.

RQIA would like to thank the residents and 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. The inspector spoke to management and staff about how they plan, deliver and monitor the management of medicines.

4.0 What people told us about the service

The inspector met with care staff, the deputy manager and the manager. 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 and said that the team communicated well. They said that they had the appropriate training to look after residents and meet their needs.

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 inspection on 21 & 28 June 2022		
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 5 and 6 **Stated:** First time	The registered person shall ensure the following in regards to resident care records: • resident involvement in the assessment and care planning process should be evidenced • care records and assessments, as appropriate, are signed by the resident • care plans are discontinued when no longer appropriate to the residents care; e.g. infection • care records contain a recent photograph of the resident.	**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.	
Area for improvement 2 **Ref:** Standard 7 **Stated:** First time	The registered person shall ensure when restrictive measures are required; the appropriate documentation is completed in full to evidence consent and consultation with residents, relatives and other relevant personnel where appropriate.	**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.	

Area for improvement 3 **Ref:** Standard 20.10 **Stated:** First time	The registered person shall ensure care record audits are completed regularly, the care record audit should include an action plan with time frames, the person responsible for completion and a follow up to ensure the deficits have been addressed.	**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.

Copies of residents' prescriptions 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 distressed reactions was reviewed for three residents.

Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain, infection or constipation. Staff advised that these medicines were seldom required and this was evidenced during the inspection. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. The reason for and outcome of each administration had been recorded when these medicines were administered.

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. Care plans were in place and reviewed regularly.

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 and nutritional supplements were 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.

Care plans were in place when residents required insulin to manage their diabetes. There was sufficient detail in the care plan to direct staff if the resident's blood sugar was outside the recommended range. Insulin was administered by the district nurse.

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. Medicine refrigerators and controlled drugs cabinets 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.

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 reviewed were found to have been fully and accurately completed. The records were filed once completed and readily retrievable for review.

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 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.

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new residents or residents returning from hospital. Written confirmation of the resident's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

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. A robust audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. 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.

The audits completed at the inspection indicated that medicines were being administered as prescribed. One discrepancy involving a controlled drug pain patch was discussed with the manager on the day of inspection for investigation and review. An incident report detailing the outcome of the investigation and action taken to prevent a recurrence was submitted to RQIA on 18 November 2022.

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

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.

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	3*

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

This inspection resulted in no new areas for improvement. Findings of the inspection were discussed with Mrs Una Brady, Registered Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan

Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)	
Area for improvement 1 **Ref:** Standard 5 and 6 **Stated:** First time **To be completed by:** 31 July 2022	The registered person shall ensure the following in regards to resident care records: • resident involvement in the assessment and care planning process should be evidenced • care records and assessments, as appropriate, are signed by the resident • care plans are discontinued when no longer appropriate to the residents care; e.g. infection • care records contain a recent photograph of the resident.
	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. Ref: 5.1
Area for improvement 2 **Ref:** Standard 7 **Stated:** First time **To be completed by:** With immediate effect (21 June 2022)	The registered person shall ensure when restrictive measures are required; the appropriate documentation is completed in full to evidence consent and consultation with residents, relatives and other relevant personnel where appropriate.
	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. Ref: 5.1
Area for improvement 3 **Ref:** Standard 20.10 **Stated:** First time **To be completed by:** 30 June 2022	The registered person shall ensure care record audits are completed regularly, the care record audit should include an action plan with time frames, the person responsible for completion and a follow up to ensure the deficits have been addressed.
	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. Ref: 5.1

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