



Inspection Report 6 November 2020



Stewart Lodge

Type of Home: Residential Care Home
Address: 1 Ballyharry Heights, Newtownards, BT23 7GE
Tel No: 028 9182 1263
Inspector: Catherine Glover

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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 eight residents.

2.0 Service details

| | |
|---|---|
| Organisation/Registered Provider: Stewart Lodge Responsible Individual: Mrs Janet Stewart | Registered Manager and date registered: Mrs Janet Stewart |
| Person in charge at the time of inspection: Mrs Janet Stewart | Number of registered places: 8 Maximum of two residents in RC-DE category of care. |
| Categories of care: Residential Care (RC) I – Old age not falling within any other category DE – Dementia | Total number of residents in the residential care home on the day of this inspection: 7 |

3.0 Inspection focus

Following a risk assessment and to reduce the risk to residents during the pandemic outbreak, this inspection was carried out remotely.

This inspection was completed following a review of information requested and submitted to RQIA on 26 October 2020. Feedback was discussed with the manager on 6 November 2020.

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

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.

As part of the inspection process we:

- spoke to representatives of the residents
- spoke to management about how they plan, deliver and monitor the care and support provided in the home
- reviewed documents to confirm that appropriate records were kept

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

- personal medication records
- medicine administration
- medicine receipt
- care plans related to medicines management
- governance and audit
- staff training and competency

4.0 Inspection Outcome

| | Regulations | Standards |
|--|-------------|-----------|
| Total number of areas for improvement | 0 | 2 |

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Janet Stewart, Registered Provider and Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

5.0 What has this home done to meet any areas for improvement identified at the last care inspection (20 February 2020) and last medicines management inspection (17 January 2018)?

No areas for improvement were identified at the last care inspection.

| 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 ensure that written confirmation of the resident's medicine regime is obtained from the prescriber on admission. | Met |
| | Action taken as confirmed during the inspection: The admission documentation was reviewed for two residents. Written confirmation of the medicine regime had been received for both residents. | |
| Area for improvement 2 Ref: Standard 6 Stated: First time | The registered person shall ensure care plans for the management of distressed reactions and pain are in place for the relevant residents. | Met |
| | Action taken as confirmed during the inspection: There were no residents that required medicines for distressed reactions currently residing in the home. The manager was aware that should these medicines be prescribed that a care plan to direct the required care would be required. Care plans were in place for the management of pain. | |

6.0 What people told us about this home?

We asked the manager to provide contact details for residents' relatives/representatives who gave consent to be contacted by the inspector. We spoke with four residents' relatives/representatives. They all said that they were "very satisfied" with the care provided to the residents.

Comments made included:

- "My [relative] is happy and content. The staff have gone above and beyond with covid and will contact with me with any issues. (Relative) likes that it is cosy and homely."
- "Overall very happy with the care my (relative) received, staff have been amazing. (Relative) loves it there."
- "Care is second to none; my (relative) loves the place. I've never had reason to complain. Janet and Phillip are very generous when I call, they couldn't do any more."
- One visiting professional completed the online questionnaire. They responded that they were "satisfied" with all aspects of the care provided.

In conversation with Janet and Philip Stewart during feedback, they demonstrated that they knew the residents very well and were familiar with all of their choices and preferences with regards to their care. They spoke warmly of all the residents and it was evident that they were passionate about providing quality care.

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 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 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 mostly accurate and up to date. However, some topical creams and medicines that would be administered by the community nurse had not been recorded. The manager was advised to ensure that these records corresponded to the printed medicine administration records. In line with best practice, two members of staff should check and sign the personal medication records when they are written and updated to provide a double check that they are accurate. An area for improvement was identified.

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

7.2 What arrangements are in place to ensure that medicines are appropriately administered within the home?

The home has a medicine policy to guide staff in the management and administration of medicines. This policy was reviewed and we gave some feedback on how this could be enhanced. The manager advised that these amendments would be completed following the inspection.

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, when medicines are administered to a resident. A sample of these records was reviewed and found to have been fully and accurately completed.

We reviewed the audits completed by the management in the home. The audits were completed regularly but did not encompass all aspects of the management of medicines. Audits should include a review of the medicine records. The audit process should be reviewed. An area for improvement was identified.

7.3 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 for two residents who had a hospital stay and were discharged to this home. Hospital discharge letters had been received and a copy had been forwarded to the residents' GPs. The residents' personal medication records correlated with the discharge instructions. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

7.4 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 had been no medicines related incidents since the last medicines inspection. The audit system in place would help staff to identify medicine related incidents. Management were familiar with the type of incidents that should be reported.

7.5 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.

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 with regard to the management of medicines.

The outcome of this inspection concluded that all areas for improvement identified at the last medicines management inspection had been addressed. Two new areas for improvement were identified, however we can conclude that overall that the residents were being administered their medicines as prescribed by their GP.

Feedback from residents' families and friends was overwhelmingly positive.

We would like to thank the management 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 Mrs Janet Stewart, 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: First time To be completed by: From the date of inspection onwards | The registered person shall ensure that personal medication records document all of the prescribed medicines and are signed and verified by two staff members. Ref: 7.1 Response by registered person detailing the actions taken: This has been noted and actioned. |
| Area for improvement 2 Ref: Standard 30 Stated: First time To be completed by: 6 December 2020 | The registered person shall review the audit process to ensure that all aspects of the management of medicines are regularly reviewed. Ref: 7.2 Response by registered person detailing the actions taken: The audit process has been refined to include advice and guidance received. |

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



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