Inspection Report
10 September 2020

Hollygate Lodge

Type of Service: Residential Care Home
Address: 21 Hollygate Park, Carryduff, Belfast BT8 8DZ
Tel No: 028 9081 3243
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.

2.0 Service details

Organisation/Registered Provider: Hollygate Care Services Ltd **Responsible Individual:** Mr Ian George Emerson, Acting	**Registered Manager and date registered:** Ms Ellen Majella McVeigh 18 June 2018
Person in charge at the time of inspection: Ms Ellen Majella McVeigh	**Number of registered places:** 38 This number includes: • a maximum of 12 persons in RC-DE • a maximum of three named persons only in RC-LD(E) • a maximum of one named person in RC-MP
Categories of care: Residential Care (RC): I – old age not falling within any other category DE – dementia MP mental disorder excluding learning disability or dementia – over 65 years LD(E) – learning disability – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 33

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 10 September 2020 from 10.00 to 15.15.

This inspection focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified 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 residents
- 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 records was examined and/or discussed during the inspection:

- personal medication records, medicine administarion records, medicine receipt and disposal records
- controlled drug records
- care plans related to medicines management
- governance and audit
- management of medication incidents
- staff training and competency records
- medicine storage temperatures
- RQIA registration certificate.

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	1	3

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Ellen McVeigh, Registered Manager, and Ms Violet Glover, Team Leader, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

5.0 What has this service done to meet any areas for improvement identified at the last care inspection (7 January 2020) and last medicines management inspection (8 December 2017)?

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 review the management of distressed reactions to ensure that care plans are in place. The reason for and outcome of each administration should be recorded.	**Met**
	Action taken as confirmed during the inspection: We reviewed the management of distressed reactions. Care plans which provided sufficient detail to direct the required care were in place. The reason for and outcome of each administration were recorded. These medicines were required infrequently. This area for improvement is met.	
Areas for improvement from the last care 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 27 **Stated:** First time	The registered person shall ensure that the identified environmental issues as outlined in this report are addressed.	**Met**
	Action taken as confirmed during the inspection: We reviewed the environmental issues which had been identified at the last inspection. The identified folding doors had been replaced. The frayed bedroom carpet had been replaced. The shelves in the sluice had been repainted and the toilet lid had been replaced. This area for improvement is met.	

Area for improvement 2 **Ref:** Standard 5 and 6 **Stated:** First time	The registered person shall ensure that care records include the date the assessment of needs is undertaken or reviewed, care plans should be devised for short term conditions such as infection which require treatment and this is fully recorded in the progress notes. Care plans reviews should ensure that the current needs of residents are reflected.	**Met**
	Action taken as confirmed during the inspection: We reviewed a sample of care records which confirmed this area for improvement had been met.	
Area for improvement 3 **Ref:** Standard 8.2 **Stated:** First time	The registered person shall ensure that progress notes are updated at least weekly or more frequently dependent upon the current needs of the residents.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that the majority of residents were well. Their progress notes were updated every three/four days. Progress notes were updated more frequently when a residents needs increased e.g. due to an infection or loss of appetite. This area for improvement is met.	
Area for improvement 4 **Ref:** Standard 8.2 **Stated:** First time	The registered person shall ensure that all staff are aware of the location of supplementary care charts such as food and fluid charts. When in place these need to reflect the resident's intake across the 24 hour period.	**Met**
	Action taken as confirmed during the inspection: Staff were aware of the location of the supplementary care charts. We reviewed a fluid intake chart and a food intake chart. The residents'intake over 24 hours had been recorded on most days. This area for improvement is met.	

Area for improvement 5 **Ref:** Standard 23.4 **Stated:** First time	The registered person shall ensure that further training and guidance is provided for staff in the recording required for care records.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that care staff received supervision on the recording required for care records following the last care inspection. In addition, the registered manager completes care plan audits. A sample of the resultant action plans were available for inspection and were satisfactory. Ongoing guidance is provided to staff by the management team based on the findings of their care plan audits. This area for improvement is met.	

6.0 What people told us about this service?

Residents were relaxing in the reception area when we arrived in the home. We also observed residents being assisted to the dining room for lunch. There was a jovial atmosphere in the home and it was evident that the staff knew the residents well.

We spoke with several residents throughout the inspection. Comments made included:

- "Staff could not be better. I love it here. The lunch was delicious."
- "The staff are very good. This one is my friend."
- "The staff are very good. I am in no pain and sleep well. The food is good."

We met with the four care staff, the team leader and the registered 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. 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 registered manager for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes.

Nine residents completed and returned the questionnaires. Their responses indicated that they were satisfied with all aspects of care. One resident commented:

- "Manager and staff doing an excellent job keeping us all safe at this time."

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 local 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.

We identified that some personal medication records were not up to date with the most recent prescription and some were incomplete. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff may not use these records as part of the administration of medicines process. The following improvements were necessary:

- the date of writing should be recorded
- the allergy status of the resident should be recorded
- two members of staff should verify and sign the personal medication records at the time of writing and at each update to ensure accuracy
- the personal medication records should be up to date i.e. newly prescribed medicines should be recorded and discontinued medicines should be cancelled
- where a medicine is administered by the community nursing team, this should be recorded.

An area for improvement with regards to the standard of maintenance of the personal medication records 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, antibiotics, warfarin, modified diets, self-administration etc.

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.

We reviewed the management of distressed reactions. Care plans which provided sufficient detail to direct the required care were in place. The reason for and outcome of each administration were recorded. These medicines were required infrequently.

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. However, care plans to direct the required care were not in place. An area for improvement was identified.

Care plans were in place when residents were prescribed warfarin and antibiotics.

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. It was noted that the key to the medicines refrigerator was in the door. Staff advised that this was to ensure that there was no delay when the community nursing team required access to medicines which required cold storage. Medicines must be stored securely to prevent unauthorised access. An area for improvement was identified.

We reviewed the disposal arrangements for medicines. Discontinued medicines were usually returned to the community pharmacy for disposal and records maintained. Due to the pandemic the community pharmacy were unable to accept returns. The registered manager advised that medicines awaiting disposal were stored in a locked room to which only she had access.

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.

Within the home, a record of the administration of medicines is completed. A sample of the medication administration records was reviewed. Most of the records were found to have been

fully and accurately completed. However, hand-written updates on the medication administration records had not been verified and signed by two staff. This is necessary to ensure the accuracy of transcription. An area for improvement was identified.

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 are recorded in a controlled drug record book. We found that controlled drugs were safely managed in the home and that records were accurately maintained.

Running stock balances were maintained for all medicines to ensure that any errors would be identified without delay. In addition the management team completed monthly audits. 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 for one resident who had a recent hospital stay and was discharged back to this home. A hospital discharge letter had been received and a copy had been forwarded to the resident's GP. The resident's personal medication records had been updated to reflect medication changes which had been initiated during the hospital stay. Their medicines had been accurately received into the home and administered in accordance with the most recent directions. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration. However, as identified above the hand-written medication administration record had not been signed and verified by two trained staff.

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.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. 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.

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.

8.0 Evaluation of Inspection

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

The outcome of this inspection concluded that all areas for improvement identified at the last care and medicines management inspections had been addressed.

Four new areas for improvement in relation to the standard of maintenance of the personal medication records, verifying hand-written updates on the medication administration records, care plans in relation to pain and the secure storage of medicines which require refrigeration were identified.

Whilst we identified areas for improvement, we can conclude that 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 Ellen McVeigh, Registered Manager, and Ms Violet Glover, Team Leader, 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 service

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.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 13 (4)(a)

Stated: First time

To be completed by:
From the date of the inspection onwards</td><td>The registered person shall ensure that medicines which require cold storage are stored securely to prevent unauthorised access.

Ref: 7.2</td></tr>
<tr><td>Response by registered person detailing the actions taken:

Review complted by manager and all senior staff are aware to keep the key of refridgerator with them throughout their shift, handing it over to senior on next shift.</td></tr>
<tr><td colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 31

Stated: First time

To be completed by:
From the date of inspection onwards</td><td>The registered person shall ensure that the necessary improvements are implemented on the personal medication records.

Ref: 7.1</td></tr>
<tr><td>Response by registered person detailing the actions taken:
All new card index have been put in place since the inspection to ensure areas identified have been rectified.
This includes allergies, dates, and signed by two staff
In addition any medicines adminsistered by district nursing is recorded in each residents card index.</td></tr>
</table>

Area for improvement 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** From the date of inspection onwards	The registered person shall ensure that care plans for the management of pain are in place. Ref: 7.1
	Response by registered person detailing the actions taken: Keyworkers have been advised to ensure that pain mangement is included and reviewed for each resident. The manager will ensure this is completed and will remain ongoing as change occur.
Area for improvement 3 **Ref**: Standard 31 **Stated:** First time **To be completed by:** From the date of inspection onwards	The registered person shall ensure that two members of staff verify and sign hand-written updates on the medication administration records. Ref: 7.3 & 7.4
	Response by registered person detailing the actions taken: All senior staff and manager attened training 21/09/20 on administration, recording, storing and returning medictaion. all staff administering medication are fully aware of the requirements and requlations to ensure medicinces are recorded and signed accordingly

The Regulation and Quality Improvement Authority

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