

# Inspection Report

8 November 2022



## Hollygate Lodge

Type of service: Residential Care Home  
Address: 21 Hollygate Park, Carryduff,  
Belfast BT8 8DZ  
Telephone number: 028 9081 3243

[www.rqia.org.uk](http://www.rqia.org.uk)

---

Assurance, Challenge and Improvement in Health and Social Care

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

## 1.0 Service information

<p><b>Organisation/Registered Provider:</b> Hollygate Care Services Ltd</p> <p><b>Responsible Individual:</b> Mr Mark Craig Emerson</p>	<p><b>Registered Manager:</b> Miss Ashley Currie</p> <p><b>Date registered:</b> 23 November 2021</p>
<p><b>Person in charge at the time of inspection:</b> Miss Ashley Currie</p>	<p><b>Number of registered places:</b> 38</p> <p>This number includes:</p> <ul style="list-style-type: none"> <li>• a maximum of twelve persons in RC-DE (mild) category of care</li> <li>• a maximum of two named persons only in RC-LD(E) category of care</li> <li>• a maximum of one named person in RC-MP category of care</li> </ul>
<p><b>Categories of care:</b> Residential Care (RC): I – old age not falling within any other category DE – dementia LD (E) - learning disability – over 65 years MP – mental disorder excluding learning disability or dementia</p>	<p><b>Number of residents accommodated in the residential care home on the day of this inspection:</b> 32</p>
<p><b>Brief description of the accommodation/how the service operates:</b></p> <p>Hollygate Lodge is a registered residential care home which provides health and social care for up to 38 residents. Accommodation is spread across three bungalows on the one site.</p>	

## 2.0 Inspection summary

An unannounced inspection took place on 8 November 2022, from 10.40am to 3.10pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

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 inspection.

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.

Review of medicines management found that residents were being administered their medicines as prescribed. There were arrangements for auditing medicines and medicine records were well maintained. Arrangements were in place to ensure that staff were trained and competent in medicines management. No new areas for improvement were identified.

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 in relation 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 the home was 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. To complete the inspection the following were reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke with staff and management about how they plan, deliver and monitor the management of medicines in the home.

### **4.0 What people told us about the service**

The inspector met with one senior carer, the deputy manager, the manager and the registered person.

Staff were warm and friendly and it was evident from discussions that they knew the residents well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The staff members spoken with expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

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 10 March 2022		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		Validation of compliance
<b>Area for improvement 1</b> <b>Ref:</b> Regulation 13 (4) (a) <b>Stated:</b> First time	The registered person shall ensure that medicines which require cold storage are stored securely to prevent unauthorised access.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b>  Medicines which required cold storage were stored securely in a locked medicines refrigerator in the treatment room.	
<b>Area for improvement 2</b> <b>Ref:</b> Regulation 29 (4) (a) <b>Stated:</b> First time	The person carrying out the Regulation 29 visit shall, where necessary, make alternative arrangements to ensure that the views and feedback of residents' representatives are sought and reflected in the written report of the conduct of the home.	<b>Carried forward to the next inspection</b>
	<b>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.</b>	
Action required to ensure compliance with Residential Care Homes Minimum Standards (2021)		Validation of compliance
<b>Area for improvement 1</b> <b>Ref:</b> Standard 12.12 <b>Stated:</b> Second time	The registered person shall ensure that where a resident's care plan requires, or when a resident chooses not to eat a meal or is unable to eat a meal, a full and accurate record is kept of all food and drinks consumed.	<b>Carried forward to the next inspection</b>
	<b>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.</b>	

<p><b>Area for improvement 2</b></p> <p><b>Ref:</b> Standard 3.4</p> <p><b>Stated:</b> Second time</p>	<p>The manager shall ensure that a referral form providing all necessary information, including any risk assessment relating to the resident and the delivery of their care and services, is completed before the resident is admitted. Any documents from the referring Trust shall be dated and signed when received.</p> <p><b>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.</b></p>	<p><b>Carried forward to the next inspection</b></p>
<p><b>Area for improvement 3</b></p> <p><b>Ref:</b> Standard 31</p> <p><b>Stated:</b> First time</p>	<p>The registered person shall ensure that two members of staff verify and sign hand-written updates on the medication administration records.</p> <p><b>Action taken as confirmed during the inspection:</b></p> <p>Two members of staff had verified and signed hand-written updates on the medication administration records to confirm accuracy.</p> <p><b>See Section 5.2.3</b></p>	<p><b>Met</b></p>
<p><b>Area for improvement 4</b></p> <p><b>Ref:</b> Standard 31</p> <p><b>Stated:</b> First time</p>	<p>The registered person shall ensure that the necessary improvements are implemented on the personal medication records.</p> <p><b>Action taken as confirmed during the inspection:</b></p> <p>The personal medication records were maintained to a mostly satisfactory standard.</p> <p><b>See Section 5.2.1</b></p>	<p><b>Met</b></p>
<p><b>Area for improvement 5</b></p> <p><b>Ref:</b> Standard 25.1</p> <p><b>Stated:</b> First time</p>	<p>The manager shall undertake a review of current staffing arrangements. The manager must ensure that planned staffing levels are sufficient to meet resident's assessed needs at all times. This review should include consideration of resident's dependency levels, the social and recreational needs of residents, and take into account the size and layout of the home.</p>	<p><b>Carried forward to the next inspection</b></p>

	<b>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.</b>	
<b>Area for improvement 6</b> <b>Ref:</b> Standard 19.2 <b>Stated:</b> First time	The registered person must ensure that, before making an offer of employment, any gaps in an employment record are explored and explanations recorded.	<b>Carried forward to the next inspection</b>
	<b>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.</b>	

## 5.2 Inspection findings

### 5.2.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in residential 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 may 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 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 safe practice, a second member of staff had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. The date of writing had not been recorded on a small number of records. It was agreed that this would be actioned immediately and monitored through the audit process.

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 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 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 two residents. Staff knew how to recognise signs, symptoms and triggers which may cause 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. Care plans directing the use of these medicines were available for one resident only; it was agreed that the remaining care plan would be written following the inspection. Records of administration were maintained. The reason for and outcome of administration had not been recorded on all occasions. It was agreed that this would be discussed with staff and monitored through the audit process.

The management of pain was reviewed. 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.

Care plans were in place when residents required insulin to manage their diabetes. There was sufficient detail in the care plans to direct staff if the resident's blood sugar was outside their target range.

### **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.

The daily records for the medicines refrigerator and treatment room temperature indicated that medicines were stored at the manufacturers' recommended temperatures. It was agreed that the room temperature of the overstock cupboard will also be monitored daily.

Appropriate arrangements were in place for the 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 had been completed in a satisfactory manner. Handwritten medicine administration records had been verified and signed by two staff to ensure accuracy of transcription. It was agreed that the time of administration would be clearly recorded on the pre-printed MARs rather than lunch, teatime etc.

Management and staff audited the management and administration of medicines on a monthly basis. In addition running stock balances were maintained for medicines which were not supplied in the monitored dosage system. The audits completed at the inspection indicated that medicines were administered as prescribed.

### **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 residents new to the home or 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. Medicines had been administered as prescribed.

### **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.

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 manager had recently implemented several changes to the medication system to drive improvements and reduce the likelihood of an error occurring. Staff said that the changes enabled them to carry out the medicine rounds in a more methodical manner. The manager and staff were commended for their ongoing efforts.



### 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. Policies and procedures should be up to date and readily available.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Update training and competency assessments had been completed in June 2022 and July 2022. Records were available for inspection.

## 6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	1*	4*

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

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Miss Ashley Currie, Registered Manager, as part of the inspection process and can be found in the main body of the report.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 29 (4) (a)  <b>Stated:</b> First time  <b>To be completed by:</b> From the date of inspection onwards (10 March 2022)	<p>The person carrying out the Regulation 29 visit shall, where necessary, make alternative arrangements to ensure that the views and feedback of residents' representatives are sought and reflected in the written report of the conduct of the home.</p>
	<p><b>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.</b></p> <p>Ref: 5.1</p>
<b>Action required to ensure compliance with Residential Care Homes Minimum Standards 2021</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 12.12  <b>Stated:</b> Second time  <b>To be completed by:</b> From the date of inspection onwards (10 March 2022)	<p>The registered person shall ensure that where a resident's care plan requires, or when a resident chooses not to eat a meal or is unable to eat a meal, a full and accurate record is kept of all food and drinks consumed.</p>
	<p><b>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.</b></p> <p>Ref: 5.1</p>
<b>Area for improvement 2</b>  <b>Ref:</b> Standard 3.4  <b>Stated:</b> Second time  <b>To be completed by:</b> From the date of inspection onwards (10 March 2022)	<p>The manager shall ensure that a referral form providing all necessary information, including any risk assessment relating to the resident and the delivery of their care and services, is completed before the resident is admitted. Any documents from the referring Trust shall be dated and signed when received.</p>
	<p><b>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.</b></p> <p>Ref: 5.1</p>
<b>Area for improvement 3</b>  <b>Ref:</b> Standard 25.1  <b>Stated:</b> First time  <b>To be completed by:</b>	<p>The manager shall undertake a review of current staffing arrangements. The manager must ensure that planned staffing levels are sufficient to meet resident's assessed needs at all times. This review should include consideration of resident's dependency levels, the social and recreational needs of residents, and take into account the size and layout of the home.</p>

<p>From the date of inspection onwards (10 March 2022)</p>	<p><b>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.</b></p> <p>Ref: 5.1</p>
<p><b>Area for improvement 4</b></p> <p><b>Ref:</b> Standard 19.2</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> From the date of inspection onwards (10 March 2022)</p>	<p>The registered person must ensure that, before making an offer of employment, any gaps in an employment record are explored and explanations recorded.</p> <hr/> <p><b>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.</b></p> <p>Ref: 5.1</p>



The Regulation and  
Quality Improvement  
Authority

The Regulation and Quality Improvement Authority

7th Floor, Victoria House  
15-27 Gloucester Street  
Belfast  
BT1 4LS

**Tel** 028 9536 1111

**Email** [info@rqia.org.uk](mailto:info@rqia.org.uk)

**Web** [www.rqia.org.uk](http://www.rqia.org.uk)

 [@RQIANews](https://twitter.com/RQIANews)

Assurance, Challenge and Improvement in Health and Social Care