

# Inspection Report

9 November 2023



## Scrabo House

Type of service: Residential Care Home  
Address: 203 Scrabo Road, Newtownards, BT23 4SJ  
Telephone number: 028 9182 6384

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

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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

<b>Organisation/Registered Provider:</b> Scrabo House  <b>Responsible Individual:</b> Mr Alexander Buchanan	<b>Registered Manager:</b> Mr Grant Alexander Buchanan, Registration pending
<b>Person in charge at the time of inspection:</b> Mr Grant Alexander Buchanan	<b>Number of registered places:</b> 17
<b>Categories of care:</b> Residential Care (RC): I – old age not falling within any other category DE – dementia	<b>Number of residents accommodated in the residential care home on the day of this inspection:</b> 16
<b>Brief description of the accommodation/how the service operates:</b> Scrabo House is a residential care home registered to provide health and social care for up to 17 residents. Residents have access to communal lounge and dining areas.	

## 2.0 Inspection summary

An unannounced inspection took place on 9 November 2023, from 10.45am to 1.45pm. This was completed by a pharmacist inspector and focused on medicines management within the home.

At the last medicines management inspection on 20 June 2023 robust arrangements were not in place for the management of medicines. Areas for improvement were identified in relation to: the management of medicines for new admissions, maintaining accurate personal medication records, implementing a robust medicines audit system and recording the date of opening on all medicines to facilitate audit.

Following the inspection, the findings were discussed with the senior pharmacist inspector in RQIA. It was decided that the manager and staff would be given a period of time to implement the necessary improvements and that this follow up inspection would be completed to ensure that improvements had been implemented and sustained.

The outcome of this inspection evidenced that management and staff within the home had taken appropriate action to ensure the necessary improvements with regards to medicines management. Written confirmation of medicines was obtained at or prior to admission. The majority of personal medication records were accurate and up to date. The date of opening was clearly recorded on all medicines not supplied in the monitored dosage system to facilitate audit and a new audit system had been implemented to ensure any medicine related issues are

identified and reported appropriately. Staff were commended for their efforts and were reminded that the improvements must be maintained.

The areas for improvement identified at the last care inspection have been carried forward for review at the next care inspection.

RQIA would like to thank the staff and residents 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 and the auditing systems used to ensure the safe management of medicines. Staff and residents' views were also obtained. 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 the former manager, the manager and the responsible person. They said staff had received appropriate training to look after residents and meet their needs. Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well.

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 20 June 2023	
Action required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005	Validation of compliance

<p><b>Area for improvement 1</b></p> <p><b>Ref:</b> Regulation 13 (4)</p> <p><b>Stated:</b> First time</p>	<p>The registered person shall ensure that accurate personal medication records are maintained as detailed in the report.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b></p> <p>This area for improvement was assessed as met.</p> <p><b>See section 5.2.1</b></p>	<p><b>Met</b></p>
<p><b>Area for improvement 2</b></p> <p><b>Ref:</b> Regulation 13 (4)</p> <p><b>Stated:</b> First time</p>	<p>The registered person shall ensure that the process of managing medicines for new admissions is reviewed to ensure that an accurate written confirmation of medicines is obtained at or prior to admission and that medicine records are accurately completed.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b></p> <p>This area for improvement was assessed as met.</p> <p><b>See section 5.2.2</b></p>	<p><b>Met</b></p>
<p><b>Area for improvement 3</b></p> <p><b>Ref:</b> Regulation 13 (4)</p> <p><b>Stated:</b> First time</p>	<p>The registered person shall implement a robust audit system which covers all aspects of medicines management and administration to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff.</p> <hr/> <p><b>Action taken as confirmed during the inspection:</b></p> <p>This area for improvement was assessed as met.</p> <p><b>See section 5.2.3</b></p>	<p><b>Met</b></p>

<b>Action required to ensure compliance with Residential Care Homes Minimum Standards (2021)</b>		<b>Validation of compliance</b>
<b>Area for Improvement 1</b>  <b>Ref:</b> Standard 5.4 and 5.5  <b>Stated:</b> Second time	The registered person shall ensure needs and risk assessments are signed and dated by the member of staff responsible for carrying it out. Falls risk assessments are amended and updated as changes occur, including actions taken by the home to manage the risk.	<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>	
<b>Area for improvement 2</b>  <b>Ref:</b> Standard 20.10  <b>Stated:</b> First time	The registered person shall ensure that a care record audit is developed and includes the monitoring of residents' care plans to encompass daily social preferences and any assessed physical needs.	<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>	
<b>Area for improvement 3</b>  <b>Ref:</b> Standard 30  <b>Stated:</b> First time	The registered person shall ensure that the date of opening is recorded on all boxed medicines to facilitate audit.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b>  This area for improvement was assessed as met.  <b>See section 5.2.4</b>	

## 5.2 Inspection findings

### 5.2.1 Personal medication records

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 mostly accurate and up to date. One minor discrepancy was highlighted to staff for remedial action. In line with best practice, a second member of staff had checked and signed the majority of personal medication records when they were written and updated to state that they were accurate.

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.

### **5.2.2 New admissions**

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 patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed; however, one personal medication record had not been signed and verified by two staff members. This expected practice was highlighted to staff.

### **5.2.3 Audit**

Management had implemented a medicines management audit system including running balances on all medicines not supplied in the monitored dosage system and a weekly audit of these medicines. There were also monthly audits on care plans and medicine records. The audits completed at the inspection indicated that medicines were being administered as prescribed.

### **5.2.4 Medicines not supplied in the monitored dosage system**

The date of opening was recorded on all medicines not supplied in the monitored dosage system so that they could be easily audited. This is good practice. The audits completed at the inspection indicated that medicines were being administered as prescribed.

## 6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	0	2*

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

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mr Grant Buchanan, 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 Residential Care Homes Minimum Standards 2021	
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 5.4 and 5.5  <b>Stated:</b> Second time  <b>To be completed by:</b> 28 February 2023	The registered person shall ensure needs and risk assessments are signed and dated by the member of staff responsible for carrying it out. Falls risk assessments are amended and updated as changes occur, including actions taken by the home to manage the risk.  <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>  Ref: 5.1
<b>Area for improvement 2</b>  <b>Ref:</b> Standard 20.10  <b>Stated:</b> First time  <b>To be completed by:</b> 1 April 2023	The registered person shall ensure that a care record audit is developed and includes the monitoring of residents' care plans to encompass daily social preferences and any assessed physical needs.  <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>  Ref: 5.1



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)

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