The Regulation and Quality Improvement Authority

Inspection Report

13 June 2023

Rosevale Lodge

Type of service: Nursing (NH)
Address: Garden Suite, 173 Moira Rd, Lisburn, BT28 1RW
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Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Healthcare Ireland No 2 Ltd **Responsible Individual:** Ms Amanda Celine Mitchell	**Registered Manager:** Ms Cheryl Palmer **Date registered:** Awaiting registration
Person in charge/Person met at the time of inspection: Ms Cheryl Palmer	**Number of registered places:** 30
Categories of care: NH – DE	**Number of residents accommodated in the home on the day of this inspection:** 28
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide care for a maximum of thirty patients with a dementia care category classification .	

2.0 Inspection summary

An announced combined estates & care inspection took place on 13 May 2023, from 10:00am to 11:45am in connection with variation application ref VA011585. See sections 4.2 and 4.3 respectively.

The inspection focused on the newly adapted sections of the premises associated with the variation application to provide two additional en-suite bedrooms, additional activity/sitting space, visitor`s WC and storage space.

The maximum number of registered patients will increase from 30 to 32 as a result of this proposed variation application.

Alongside this, a medicines management inspection was also carried out within the home to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management. This was completed by a pharmacist inspector. See section 4.4.

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 complete the medicines management part of 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 The inspection findings

4.1 What has this service done to meet any areas for improvement identified at or since last inspection?

<table>
<tr><th colspan="3">Areas for improvement from the last inspection on 20 January 2023, RQIA ref IN040537</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 4

Stated: Second time

To be completed by:
17 February 2023</td><td>The registered person shall ensure that handwritten care records are legible.

Ref: 5.2.2</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Not reviewed by inspector</td></tr>
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4.2 Estates Inspector findings

Is the newly adapted section of the home compliant with the Department of Health's (DoH) Residential Care Homes Minimum Standards and with other relevant legislative requirements and Approved Codes of Practice (ACOPs)?

Building alterations were completed in the existing premises to provide two additional bedrooms with ensuite shower/WC facilities and washbasins.
Lounge and dining accommodation was increasd by the addition of a single storey extension adjacent a rear external corner of the building.
New bedroom sizes exceeded the 12 sq m minimum standard requirement and the interior building fabric was completed to a good standard.

The required pre-registration documents were assessed, approved and recorded prior to the inspection.
Documents submission included statutory approvals, proposed floor plans, fire risk assessment and water safety/legionella risk assessment.

The accommodation modified & extended as specified in this variation application was inspected and found to be compliant with current DoH minimum standards.

The fire risk assessment and legionella risk assessment documents had been reviewed and action plan recommendations implemented.
From an estates inspector`s perspective this variation application has complied with the estates registatration requirements listed in the current care standards and therefore this application may be processed to completion.

No areas for improvement were identified.

4.3 Care Inspector findings.

The manager confirmed that staffing levels were planned to increase in line with the increase in patient occupancy. Discussion with the management team evidenced that staffing arrangements remained subject to regular review and consideration had been given to staffing levels and skill mix, patient dependencies, and the building layout.

There were systems in place to ensure that staff were trained and supported to do their job and to deliver effective care. Staff demonstrated awareness about the planned increase in patient occupancy and were knowledgeable about the new room numbers and layouts.

The new bedrooms were clean, spacious, well decorated, suitably furnished, and had ample natural light. The fixtures, fittings, and furnishings within the bedrooms were compliant with the Care Standards for Nursing Homes (2015).

The new communal spaces were clean and well-lit with welcoming décor. The manager confirmed that additional dining furniture had been ordered to facilitate potential overflow of dining room spaces into the new extension.

It was established that the nurse call bell system within the new rooms was installed and in working order. The nurse call bell panel correctly displayed the new room numbers and staff responded in a timely manner.

The management team confirmed that the new bedrooms were captured in the home's governance systems to ensure ongoing monitoring of the quality of care and services. For example, environmental and infection prevention and control (IPC) audits.

Fire safety measures were in place. For example, a fire risk assessment was in place, and the manager confirmed that the new rooms would be captured in future fire drill practices for staff.

In conclusion, from a care perspective RQIA were satisfied that the actions taken in relation to this variation are compliant with current DoH minimum standards and may be processed to completion.

No areas for improvement were identified.

4.4 Pharmacist Inspector findings

Personal medication records

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 a 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 and 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 verified and signed the personal medication records when they were written and updated to confirm that they were accurate.

Medicine supply and storage

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.

Records of medicines received into the home must be accurately maintained to provide a clear audit trail to show that medicines have been received into the home in a timely manner, commenced without delay and administered as prescribed.

The records inspected showed that medicines were available for administration when residents required them. The manager 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.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. The current temperature of the medicine refrigerator was monitored each day; this does not provide evidence that the temperature is maintained within the required range at all times. Guidance on how to accurately monitor and record the refrigerator temperature was provided for the manager and regional manager who gave an assurance that the maximum, minimum and current refrigerator temperatures would be monitored from the date of the inspection onwards.
Satisfactory arrangements were in place for the safe disposal of medicines.

Medicine administration

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.

A sample of the medicine administration records was reviewed. Records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Management and staff audited medicine administration on a regular basis within the home. The majority of medicines were supplied in a monitored dosage system. The audits completed at the inspection indicated that medicines were administered as prescribed.

Care plans in relation to medicines management

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 nurses 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.

These medicines were prescribed for a small number of residents and were rarely needed. Directions for use were recorded on the personal medication records. The reason for and outcome of administration had been recorded in the daily care notes. Care plans were in place. It was agreed that the care plans would be updated to include the name of the prescribed medicine.

The management of pain was reviewed. Detailed care plans were in place. Staff advised that all residents could request pain relief when required.

A small number of residents self-administer some of their medicines. Care plans were in place.

Staff training and competency assessment

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

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.

Controlled drugs

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers.

A small number of controlled drugs were available. The manager advised that the administration of controlled drugs was not always witnessed by a second member of staff as there was often only one staff member on duty at the time of administration. It was agreed that a risk assessment for this practice would be put in place. Balances of controlled drugs were checked at each handover of responsibility. In addition, weekly audits were completed. The audits completed at the inspection indicated that controlled drugs were administered as prescribed.

The management of medicines on admission and medication changes

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. The medicine records had been accurately completed and there was evidence that medicines were administered in accordance with the most recent directions.

Governance and audit

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.

No areas for improvement were identified.

5.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	1*

* the total number of areas for improvement includes one that have been stated for a second time and is carried forward for review at the next inspection. This was carried forward from the previous inspection on 20 January 2023, RQIA ref IN040537.

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Ms Cheryl Palmer, Manager (awaiting registration) 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	
Area for improvement 1 **Ref:** Standard 4 **Stated:** Second time	The registered person shall ensure that handwritten care records are legible.
	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.

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