The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Rose Lodge

Provider: Rose Lodge Care Home (Lisburn) Ltd

Date of Inspection: 14 & 15 January 2025

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:	Rose Lodge Care Home (Lisburn) Ltd
Responsible Individual:	Mr Kevin McKinney
Registered Manager:	Ms Julie McAleavey, not registered
Service Profile: Rose Lodge is a nursing home registered to provide general nursing and physical disability care for up to 48 patients. The home is divided into two units, Dowling and Warnock unit – both are situated on the ground floor of the home. Patients have access to communal living and dining spaces as well as to the garden areas.	

2.0 Inspection summary

An unannounced inspection took place on 14 January 2025, from 10.00am to 4.30pm, by two pharmacist inspectors and on 15 January 2025, from 11.00am to 1.00pm, by a finance inspector. The inspection focused on medicines management and the management of patients' finances and property within the home.

The inspection was undertaken to evidence how medicines and patients' finances are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management and patients' finances. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine related care plans were generally well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered the majority of their medicines as prescribed. However, improvements were necessary in relation to cold storage, escalating and reporting medicine incidents appropriately and the management of medicines administered via an enteral feeding tube.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, patients were being administered their medicines as prescribed.

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients well.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, and new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

RQIA would like to thank the staff for their assistance throughout the inspection.

3.0 The inspection

3.1 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 against the regulations and standards, 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

3.2 What people told us about the service and their quality of life

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each patient liked to take their medicines. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

No completed questionnaires or responses to the staff survey were received following the inspection.

3.3 Inspection findings

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

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' 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.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. 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 were accurate and up to date. In line with best 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. A small number of minor discrepancies were highlighted to nurses for immediate corrective action and on-going vigilance.

Copies of patients' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

All patients 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.

Patients 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 patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Directions for use were recorded on the personal medication record and patient-centred care plans were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. Records of administration included the reason for and outcome of each administration. One care plan required an update to include the name of the prescribed medicine and the manager was reminded that the maximum daily dose should be recorded on the personal medication record. Assurances were provided that this would be actioned immediately.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans were in place and reviewed regularly.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

The management of thickening agents and nutritional supplements was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined.

Records of administration of the nutritional supplement and water were maintained. Staff advised that they had received training and felt confident to manage medicines and nutrition via the enteral route. However, an up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was not in place and the care plan required an update. An area for improvement was identified.

3.3.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient'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 reviewed showed that one medicine had been omitted on four consecutive days because the medicine was not available in the home. This had not been escalated to management for immediate action and investigation to prevent a recurrence. Medicines must be available for administration as prescribed. See section 3.3.5.

The medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately.

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. Two medicine refrigerators were in use but records were only maintained for one of the medicine refrigerators. An area for improvement was identified.

The manager was reminded that medicines awaiting collection for disposal should be stored securely to prevent unauthorised access and collected in a timely manner.

3.3.3 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 patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. Most of the records were found to have been accurately completed. A small number of minor discrepancies were brought to the attention of the manager for ongoing monitoring. Records were filed once completed and were readily retrievable for audit/review.

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 should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits had been discussed with staff and addressed. The date of opening was recorded on medicines to facilitate audit and disposal at expiry.

3.3.4 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 at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

3.3.5 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. A robust audit system will help staff to identify medicine related incidents.

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 the learning shared with staff in order to prevent a recurrence. However, two incidents identified at the inspection had not been escalated to management for immediate action, investigation to prevent a recurrence and reporting to RQIA. The inspector signposted staff to the RQIA provider guidance in relation to the statutory notification of medication related incidents available on the RQIA website to ensure that staff are familiar with the type of incidents that should be reported. An area for improvement was identified.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with the manager for on-going monitoring.

3.3.6 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 patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that they staff are competent in managing medicines and that they are supported.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

3.3.7 Finance inspection

It is the policy of the home for patients to manage their own monies. However, in line with The Nursing Homes Regulations (NI) 2005, a safe place was available for patients to deposit items for safekeeping when required. A review of records confirmed that no monies or valuables were held on behalf of patients at the time of the inspection on 15 January 2025.

Discussion with the manager confirmed that no bank accounts were used to retain patients' monies and no member of staff was the appointee for any patient, namely a person authorised by the Department for Communities to receive and manage the social security benefits on behalf of an individual.

Three patients' finance files were reviewed. Written agreements were retained within two of the files. The agreements included the details of the weekly fee paid by, or on behalf of, the patients and a list of services provided to patients as part of their weekly fee. Both agreements were signed by the patient, or their representative, and a representative from the home.

There was evidence that a review of patients' agreements was being undertaken at the time of the inspection on 15 January 2025. The review was to ensure that all patients' agreements were in place, up to date and signed by the patients or their representatives (where possible).

The manager provided assurances that the review would be completed by 31 March 2025. The patients' agreements will be reviewed again at the next RQIA inspection.

Review of records confirmed that a weekly third party contribution (top up) was paid on behalf of newly admitted care managed patients. Discussion with the manager confirmed that the third party contribution was not for any additional services provided to patients but the difference between the tariff for the home and the regional rate paid by the health and social care Trusts.

A review of a sample of records of fees received from one patient evidenced that the records were up to date at the time of the inspection. Discussion with the manager confirmed that no patient was paying an additional amount towards their fee over and above the amount agreed with the health and social care trusts.

Discussion with the manager confirmed that hairdresser and podiatry services provided to patients were paid by the home. No purchases were undertaken by members of staff on behalf of patients.

A sample of one patient's file evidenced that a property record was in place. The record was updated with additional items brought into the patients' room following admission. There was no recorded evidence to show that the personal possessions were checked at least quarterly. The manager informed the inspector on 15 January 2025 that the system for recording all patients' personal property was under review and provided assurances that a revised system would be implemented by 15 March 2025. This will be reviewed at the next RQIA inspection.

Discussion with the manager confirmed that no transport scheme was in place at the time of the inspection on 15 January 2025.

No new finance related areas for improvement were identified during the inspection on 15 January 2025.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	2*	9*

* the total number of areas for improvement includes eight which were carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Julie McAleavey, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 30 (1) (d) **Stated:** First Time **To be completed by:** Immediate and ongoing (14 January 2025)	The registered person shall ensure that RQIA are notified of the occurrence of any even in the nursing home which adversely affects the wellbeing or safety of any patient. This area for improvement is made in relation to medicine incidents. Ref: 3.3.2 & 3.3.5
	Response by registered person detailing the actions taken: All staff nurses have been made aware by the Interim manager of reporting all medication incidents. This information was disseminated during a staff nurse meeting which took place in January and a copy of the RQIA Statutory Notification of Medication Related Incidents has been placed in the treatment room for staff nurses to refer to.
Area for improvement 2 **Ref:** Regulation 29 **Stated:** First Time **To be completed by:** 28 February 2025	The registered person shall ensure that the Regulation 29 monitoring visits are robust and clear on the actions required to drive the necessary improvements to ensure compliance with regulations and standards.
	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. Ref: 2.0
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 28 **Stated:** First time **To be completed by:** Immediate and ongoing (14 January 2025)	The registered person shall review the management of medicines and nutrition via the enteral route to ensure that an up to date regimen and a care plan are in place to direct care. Ref: 3.3.1
	Response by registered person detailing the actions taken: The Interim Manager will ensure that any resident receiving nutrition or medication via the enteral route has a laminated copy of their regime provided by dietetics on their wall and fully documented in their care plan.

Area for improvement 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** Immediate and ongoing (14 January 2025)	The registered person shall ensure that the maximum, minimum and current temperature of both medicine refrigerators is monitored and recorded daily and that appropriate action is taken if the temperature recorded is outside the recommended range of 2-8^{o}C. Ref: 3.3.2
	Response by registered person detailing the actions taken: There is now 2 files in place in the treatment room, one for each fridge, these are labelled. The minimum, maximum and current temperature are recorded for both in the morning and at night. These are audited at the end of each month.
Area for improvement 3 **Ref:** Standard 21.1 **Stated:** Second time **To be completed by:** 31 January 2025	The registered person shall review the provision of wound care to ensure that wounds are managed in keeping with best practice guidance.
	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. Ref: 2.0
Area for improvement 4 **Ref:** Standard 41.1 **Stated:** First time **To be completed by:** 28 February 2025	The registered person shall ensure that staffing levels are reviewed to ensure that there are adequate staffing levels on at all times. The review should take account of but not limited to dependencies of patients and the layout of the building.
	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. Ref: 2.0
Area for improvement 5 **Ref:** Standard 41.1 **Stated:** First time **To be completed by:** 31 January 2025	The registered person shall ensure that the duty rota identifies the nurse in charge of the home on each shift.
	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. Ref: 2.0

Area for improvement 6 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 31 December 2024	The registered person shall ensure that the daily menu is clearly displayed in a suitable format and location in order that patients know what the choices are at each mealtime.
	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. Ref: 2.0
Area for improvement 7 **Ref:** Standard 12 **Stated:** First time **To be completed by:** 31 January 2025	The registered person shall ensure that variations to the planned menu are recorded.
	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. Ref: 2.0
Area for improvement 8 **Ref:** Standard 46.11 **Stated:** First time **To be completed by:** 31 January 2025	The responsible person shall ensure that staff are aware of their responsibilities regarding maintaining effective IPC measures. This is in relation to the use of nail polish and its impact on effective hand hygiene.
	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. Ref: 2.0
Area for improvement 9 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 28 February 2025	The registered person shall ensure that deficits identified by the homes care record audits are included in an action plan that clearly identifies the person responsible to make the improvement and the timeframe for completing the improvement.
	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. Ref: 2.0

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews