The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Newcroft Lodge

Provider: South Eastern HSC Trust

Date of Inspection: 6 May 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:	South Eastern HSC Trust
Responsible Individual:	Ms Roisin Coulter
Registered Manager:	Mrs Demi McKee
Service Profile: Newcroft Lodge is a residential care home registered to provide health and social care for up to 29 residents living with dementia. The home is on the ground floor with access to a number of communal areas and outdoor space for residents.	

2.0 Inspection summary

An unannounced inspection took place on 6 May 2025, from 10.10am to 14.00pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines 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. The inspection also reviewed the area for improvement identified at the last medicines management inspection. 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 records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. However, areas for improvement were identified in relation to cold storage, recording dates of opening to facilitate audit and the management of medicines prescribed to be administered as a short course.

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

The area for improvement in relation to dosage changes, identified at the last medicines management inspection, was assessed as met. 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).

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

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 residents, 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 residents 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.

RQIA did not receive any completed questionnaires from residents or responses to the staff survey 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?

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 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 staff for immediate corrective action and on-going vigilance.

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

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.

The management of distressed reactions, pain and epilepsy were reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed.

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 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 reviewed 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 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 resident could be easily located. Temperatures of medicine storage areas were monitored and recorded. Satisfactory arrangements were in place the storage of controlled drugs.

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 however the thermometer was not reset after each reading, this does not provide evidence that the temperature is maintained within the required range at all times. An area for improvement was identified.

Satisfactory arrangements were in place for the safe disposal of medicines.

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 residents 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. See Section 3.3.4. A small number of missed second verification signatures 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.

Occasionally, residents may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the resident's care plan. Care plans contained sufficient detail to describe how the resident's medicines were administered.

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 majority of the audits completed at the inspection indicated that the medicines were administered as prescribed. However, a significant number of audits could not be completed as the dates of opening had not been recorded. The date of opening must be recorded on all medicines to facilitate audit and disposal at expiry. An area for improvement was identified.

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.

Discharge medicines for one resident returning from hospital were accurately recorded onto the personal medication record and written confirmation of the medicine was obtained and shared with the GP. However, two medicines which were prescribed as short courses had not been discontinued on the medication administration record or removed from the refrigerator which resulted in extra administrations beyond the prescriber's intended duration of treatment. Corrective action was taken at the inspection and an incident report was submitted to RQIA. Robust systems must be in place to ensure that short term courses are not administered beyond the prescriber's intended duration of treatment. An area for improvement was identified.

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.

One medicine related incident had been reported to RQIA since the last medicines management inspection. Management and staff advised that they were familiar with the type of incidents that should be reported. The inspector signposted staff to the RQIA provider guidance in relation to the statutory notification of medication related incidents available on the RQIA website.

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

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

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

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	3*	6*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Demi McKee, Registered 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 Residential Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 6 May 2025	The registered person shall review the systems in place to manage medicines which are prescribed as a short course, to ensure that they are not administered beyond the prescriber's intended duration of treatment. Ref: 3.3.4 & 3.3.3
	Response by registered person detailing the actions taken: Medication Management training has been refreshed with all seniors and policy reviewed during supervision. Regular robust auditing in place.
Area for improvement 2 **Ref:** Regulation 14 (2) (c) **Stated:** First time **To be completed by:** From the date of inspection 22 August 2024	The registered person shall ensure that the storage of toiletries is risk assessed and any identified risks to residents appropriately managed.
	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
Area for improvement 3 **Ref:** Regulation 27 (4) (d) (i) **Stated:** First time **To be completed by:** From the date of inspection 22 August 2024	The registered person shall implement a system to monitor the operation of fire doors to ensure that the improvements made with staff practice are sustained and embedded into practice.
	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 Residential Homes, December 2022	
Area for improvement 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 6 May 2025	The registered person shall ensure dates of opening are recorded on medicines to facilitate audit and disposal at expiry. Ref: 3.3.3
	Response by registered person detailing the actions taken: Medication Management training has been refreshed with all seniors and policy reviewed during supervision. Regular robust auditing in place. RQIA medication audit tool now in use bi monthly.
Area for improvement 2 **Ref:** Standard 32 **Stated:** First time **To be completed by:** 6 May 2025	The registered person shall ensure that maximum and minimum refrigerator temperatures are recorded each day and that the thermometer is reset after each reading. Corrective action should be taken if temperatures are within the recommended range. Ref: 3.3.2
	Response by registered person detailing the actions taken: Fridge has been recallibrated by Estates department and minimum and maximum temperature remains checked daily.
Area for improvement 3 **Ref:** Standard 3.4 **Stated:** First time **To be completed by:** From the date of inspection 22 August 2024	The registered person shall ensure that a pre-admission assessment is completed prior to any resident being admitted to the home. These must be recorded, dated and signed.
	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 6.2 **Stated:** First time **To be completed by:** 19 September 2024	The registered person shall ensure that resident's care plans for DoLs are written with sufficient detail to meet the resident's needs.
	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 27 **Stated:** First time **To be completed by:** 27 September 2024	The registered person shall submit a rolling refurbishment plan to RQIA outlining the plans for repairs and timeframes relating to: • paintwork • woodwork • bedroom doors.
	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 13.9 **Stated:** First time **To be completed by:** 19 September 2024	The registered person shall ensure that the activity records clearly evidence: • the person leading the activity • the names of the residents who participate.
	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

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