

Inspection Report

Name of Service: Northfield House

Provider: South Eastern HSC Trust

Date of Inspection: 27 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 Caroline Diane Wilson
Service Profile: Northfield house is a registered residential care home which provides health and social care for up to 41 residents. The home is divided between two floors. Residents bedrooms are located on the ground floor. Residents have access to communal lounges, a dining room and outside space.	

2.0 Inspection summary

An unannounced inspection took place on 27 May 2025, from 10.10am to 1.15pm. 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 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, improvements were necessary in relation to the management of warfarin and the recording of room temperatures.

Whilst areas for improvement were identified, there was evidence that residents were being administered their medicines as prescribed.

Residents were observed to be relaxed and comfortable in the home and in their interactions with staff. Residents said that living in the home was a good experience.

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 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

Three questionnaires were received from a resident who was very satisfied with how their medicines were managed. Comments included: 'All the staff are very helpful', 'Pleasant environment' and 'The service is excellent'

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

No 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?

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 majority of 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. One personal medication record did not have the resident's allergies recorded, the dose and administration intervals for some "when required" medications were not fully recorded (see section 3.3.4). Although the allergies had been recorded on the resident's medication administration records and there was evidence that medicines were administered as prescribed. This was corrected on the day of inspection and discussed with the manager for on-going monitoring.

Copies of 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 warfarin was reviewed. Warfarin is a high risk medicine which requires regular blood testing. The dose of warfarin prescribed depends on the blood test result. A resident specific care plan was in place. Obsolete records had not been cancelled and archived. Transcribing of doses did not involve two staff members. A review of records evidenced that the new doses from the most recent blood tests had not been transcribed correctly, however the correct doses had been administered to the resident. 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 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 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. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs. Satisfactory arrangements were in place for the safe disposal of medicines.

Medicines must be stored at the manufacturers' recommended temperature in order to ensure their stability and efficacy; this is usually at or below 25°C for medicines recommended to be

stored at room temperature. Review of the daily treatment room temperature records evidenced temperatures had not been recorded for the previous ten days. The manager was reminded that room temperatures should be recorded in all rooms where medication is stored. An area for improvement was identified.

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. Records were found to have been accurately completed. Records were filed once completed and were readily retrievable for 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 and action plans had been implemented 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 arrangements were in place to manage medicines at the time of admission or for residents returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. The personal medicine record belonging to one resident had not been fully and accurately completed during admission (see section 3.3.1). This was corrected on the day of inspection and discussed with the manager for review and on-going monitoring. 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.

Management and staff were familiar with the type of incidents that should be reported. 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.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

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. The manger was in the process of carrying out supervision with all staff involved in medication administration.

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

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	1*	6*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Caroline Diane Wilson, 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: 30 May 2025	The registered person shall review the management of warfarin to ensure obsolete records are cancelled and archived and where transcribing of warfarin doses occurs this involves two staff members. Ref: 3.3.1 Response by registered person detailing the actions taken: All old warfarin records have been cancelled, removed and archived. Only current prescription is in the file and signed by 2 staff on all administrations.
Action required to ensure compliance with the Care Standards for Residential Homes, December 2022	
Area for improvement 1 Ref: Standard 32 Stated: First time To be completed by: 30 May 2025	The registered person shall ensure room temperatures are recorded daily in medication storage areas. Ref: 3.3.2 Response by registered person detailing the actions taken: Two thermometers have been purchased and placed in the 2 area where the medicine trolleys are stored. the clinical room washbasin has been replaced with the new one. the 2 nd one has been introduced into the room of the dining room where the medicine trolleys are stored during the day. thermometer recording has been introduced into this room as already in clinical room.
Area for improvement 2 Ref: Standard 23.3 Stated: First time To be completed by: 23 August 2024	The registered person shall ensure that staff are up to date with their mandatory training, this is with specific reference to: <ul style="list-style-type: none"> • Moving and handling practical training and, • Basic life support 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

<p>Area for improvement 3</p> <p>Ref: Standard 12.4</p> <p>Stated: First time</p> <p>To be completed by: 9 August 2024</p>	<p>The registered person shall ensure the daily menu is displayed in a suitable format.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>
<p>Area for improvement 4</p> <p>Ref: Standard 27</p> <p>Stated: First time</p> <p>To be completed by: From the date of inspection (26 July 2024)</p>	<p>The registered person shall ensure those bedrooms identified during the inspection are reverted back to their original stated purpose.</p> <p>If required, a variation should be submitted to RQIA outlining the change in the use of these areas than that of their original stated purpose.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>
<p>Area for improvement 5</p> <p>Ref: Standard 27</p> <p>Stated: First time</p> <p>To be completed by: From the date of inspection (26 July 2024)</p>	<p>The registered person shall complete a risk assessment to ensure the room identified during inspection is managed and maintained safely and securely, to reduce any potential risk to resident's safety.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>
<p>Area for improvement 5</p> <p>Ref: Standard 20.10</p> <p>Stated: First time</p> <p>To be completed by: 23 August 2024</p>	<p>The registered person shall ensure audits are; consistently completed and where deficits are identified, action plans are time-bound and signed off to evidence completion.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>

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