



The Regulation and
Quality Improvement
Authority

Inspection Report

Name of Service: Oakridge Residential Unit
Provider: Spa Nursing Homes Ltd
Date of Inspection: 13 December 2024

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:	Spa Nursing Homes Ltd
Responsible Individual:	Mr Christopher Philip Arnold
Registered Manager:	Mrs Kelly Kilpatrick
Service Profile:	
<p>Oakridge Residential Unit is a registered residential care home which provides social care for up to 10 people with dementia. The residential care home is located on the ground floor with access to an enclosed courtyard. Bedrooms are all single rooms with ensuite facilities. There is a choice of communal living and dining areas.</p> <p>There is a separate registered nursing home which occupies the first floor of the same building.</p>	

2.0 Inspection summary

An unannounced inspection took place on 13 December 2024, from 10.15am to 1.35pm. 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 disposal of medicines, including controlled drugs, records for the receipt of controlled drugs, robust controlled drug reconciliations and accurately monitoring the refrigerator temperature.

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.

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.

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

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.

Staff advised that they were familiar with how each resident liked to take their medicines and medicines were administered in accordance with individual resident preference. 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?

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. Copies of residents' prescriptions 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 warfarin was 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.

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

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Directions for use were clearly recorded on the personal medication record and resident-centred care plans were in place. Staff were reminded to update care plans as soon as possible when the parameters for administration changes. Staff knew how to recognise a change in a resident'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.

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 to ensure that medicines were stored appropriately.

Medicines which require cold storage must be stored between 2°C and 8°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. Only 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. A review of temperatures logs identified two days when the temperature was not recorded in the current month. An area for improvement was identified.

Satisfactory arrangements were in place for the storage of controlled drugs.

Records of disposal of medicines, including controlled drugs, were accurately maintained. However, medicines for disposal were being collected by a waste management company and controlled drugs were being denatured in the home prior to disposal. In residential care homes medicines, including controlled drugs, must be returned to the community pharmacy for disposal. Controlled drugs should not be denatured in the home. An area for improvement was identified.

Staff were reminded that medicines awaiting collection for disposal should be stored securely to prevent unauthorised access and returned to the community pharmacy/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 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 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 was evidence that controlled drugs were administered as prescribed, however, records of receipt for two recently received controlled drugs had not been recorded in the controlled drug record book. This had not been identified through the reconciliation checks indicating that staff had not actually counted the stock at the time of reconciliation. On the day of inspection only one staff member had signed the reconciliation check. Reconciliation checks must be carried out at each handover and records must be signed by both staff members. An area for improvement was identified.

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.

There had been no recent admissions/readmissions to the home. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the resident's medicines and this was shared with the GP and community pharmacist.

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 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 staff on duty and 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 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 the 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. Competency had been assessed following induction and annually thereafter. Medicines management policies and procedures were in place.

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	5*	2*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Kelly Kilpatrick, 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 Care Home Regulations (Northern Ireland) 2005	
Area for improvement 1 Ref: Regulation 13 (4) Stated: First time To be completed by: With immediate effect (13 December 2024)	<p>The registered person shall ensure the maximum, minimum and current temperature of the medicine refrigerator is recorded each day and the thermometer reset.</p> <p>Action should be taken if temperatures outside 2°C – 8°C are observed.</p> <p>Ref: 3.3.2</p> <hr/> <p>Response by registered person detailing the actions taken: The Registered Manager has addressed with staff daily recording of the fridge temperature. The Registered Manager has purchased a new fridge thermometer and will address any temperature ranges outside 2-8 degrees.</p>
Area for improvement 2 Ref: Regulation 13 (4) Stated: First time To be completed by: With immediate effect (13 December 2024)	<p>The registered person shall ensure that medicines, including controlled drugs, are returned to the community pharmacy for disposal.</p> <p>Ref: 3.3.2</p> <hr/> <p>Response by registered person detailing the actions taken: The Registered Manager has contacted the supplying pharmacist and all medication and controlled drugs are being returned to the community pharmacy for disposal..</p>
Area for improvement 3 Ref: Regulation 13 (4) Stated: First time To be completed by: With immediate effect (13 December 2024)	<p>The registered person shall ensure there are robust arrangements in place for the management of controlled drugs. Specifically relating to:</p> <ul style="list-style-type: none"> • the receipt of medications in the controlled drug register • accurate reconciliation checks should be carried out at each handover and signed by two staff members <p>Ref: 3.3.3</p> <hr/> <p>Response by registered person detailing the actions taken: The Registered Manager has addressed with staff the receipt of controlled drugs in the register and the reconciliation checks at each handover The Registered Manager will continue to have oversight of this to ensure records are maintained and robust arrangements are in place. .</p>

<p>Area for improvement 4</p> <p>Ref: Regulation 27 (2) (d)</p> <p>Stated: Second time</p> <p>To be completed by: 30 September 2024</p>	<p>The registered person shall ensure that the areas identified at this inspection in regards to the home's environment are addressed.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>
<p>Area for improvement 5</p> <p>Ref: Regulation 14 (2) (a) (b)</p> <p>Stated: Second time</p> <p>To be completed by: 30 September 2024</p>	<p>The registered person shall ensure as far as reasonably practical that all part of the home to which residents have access are free from hazards to their safety. This is in relation to the safe storage of toiletries and cleaning chemicals.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p>
<p>Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022</p>	
<p>Area for improvement 1</p> <p>Ref: Standard 19</p> <p>Stated: First time</p> <p>To be completed by: 17 September 2024</p>	<p>The registered person shall ensure there is evidence that gaps in staff employment are explored before staff commence working in the home.</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 2</p> <p>Ref: Standard 6</p> <p>Stated: First time</p> <p>To be completed by: 17 September 2024</p>	<p>The registered person shall ensure that when staff review residents care records that the record made is personalised to the resident.</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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