

Inspection Report

Name of Service: Woodlawn House

Provider: Southern Health and Social Care Trust

Date of Inspection: 5 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:	Southern Health and Social Care Trust
Responsible Individual:	Dr Maria O'Kane
Registered Manager:	Mrs Chanelle Crawford
Service Profile: Woodlawn House is a nursing home registered to provide nursing care for up to 9 patients. The home is divided in two units in which care is provided for people living with a learning disability. The service is used to provide a short break service to patients and their families.	

2.0 Inspection summary

An unannounced inspection took place on 5 December 2024, from 10.00am to 12.30pm. This 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 were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. However, an area for improvement was identified in relation to care plans for covert administration.

Whilst an area for improvement was identified, there was evidence that 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 the new area 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 administration was tailored to respect each individual's preferences, needs and timing requirements.

RQIA did not receive any completed questionnaires 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?

Patients bring their own medicines into the home with them at the beginning of their stay and any unused medicines are returned at the end of their stay. Following discussions with staff, it was evident that when applicable, other healthcare professionals were contacted in response to patients' needs and should medicines be prescribed during their stay arrangements were in place to ensure these were obtained in a timely manner.

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.

Since this is a short break service, patients were registered with their own GP and a personal medication record was kept on file for each patient. Arrangements were in place for the safe management of medicines for each short stay. Personal medication records/entries were signed by two members of staff. Robust procedures were in place to manage any changes during each short stay.

All patients should have care records 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 records 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 clearly recorded and care plans directing the use of these medicines 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. These medicines were used infrequently but staff advised that if they were administered nurses would record the reason for and outcome in the daily notes.

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.

An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

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

As part of the admission process staff must make the necessary arrangements to ensure that the patient's medicines are available for administration as prescribed during their stay in the home. It is important that medicines are stored safely and securely so that there is no unauthorised access and that appropriate arrangements are made to return medicines to carers at the end of the stay.

Systems were in place to ensure that sufficient medicines were supplied for each stay and any medicines remaining at the end of the stay were returned. Outside of this arrangement, arrangements were in place for the safe disposal of medicines if necessary.

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. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

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. Records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Occasionally, patients 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 patient's care plan. A care plan was not in place for one patient who had medicines administered covertly. An area for improvement was identified.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out including an audit of medicine administration at the end of each stay to check that medicines had been administered as prescribed. The date of opening was recorded on medicines so that they could be easily audited. This is good practice.

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.

The admission process for new and returning patients was discussed. Robust arrangements were in place to check current medicine regimes with the patient's representative and when necessary, to obtain a list of current medicines from the patient's GP.

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 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 ongoing improvement.

4.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	4*

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

The new area for improvement and details of the Quality Improvement Plan were discussed with the deputy 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 Care Standards for Nursing Homes (December 2022)	
<p>Area for improvement 1</p> <p>Ref: Standard 28</p> <p>Stated: First time</p> <p>To be completed by: Immediate and ongoing (5 December 2024)</p>	<p>The registered person shall ensure that written consent from the patient's GP and a care plan are in place when medicines are administered covertly.</p> <p>Ref: 3.3.3</p> <p>Response by registered person detailing the actions taken: Following review eight service users have been identified as receiving their medication covertly at Woodlawn House. GP consent is been sought in relation to the administration of covert medication to these service users. Best interest discussions will be held and care plans updated to reflect outcome of these. Care plans of all eight service users will be updated by Friday 21st February 2025.</p>
<p>Area for improvement 2</p> <p>Ref: Standard 4</p> <p>Stated: First time</p> <p>To be completed by: 14 May 2024</p>	<p>The registered person shall ensure that patients care plans are reflective of the most recent Speech and Language Therapist (SALT) recommendations and documented in accordance with the International Dysphagia Diet Standardisation Initiative (IDDSI) terminology.</p> <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 3</p> <p>Ref: Standard 4</p> <p>Stated: First time</p> <p>To be completed by: 14 May 2024</p>	<p>The registered person shall ensure that a care plan is implemented for any patient with a Deprivation of Liberty Safeguards (DoLS) and that care plans regarding enhanced supervision are reflective of the duration and level of enhanced supervision required.</p> <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 46</p> <p>Stated: First time</p> <p>To be completed by: 14 May 2024</p>	<p>The registered person shall ensure that staff are compliant with infection prevention and control (IPC) best practice and remain bare below the elbow.</p>
	<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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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