

# Inspection Report

6 August 2024



## Rosemount Care Centre

Type of service: Nursing Home  
Address: 2 Moy Road, Portadown, BT62 1QL  
Telephone number: 028 3833 1311

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Assurance, Challenge and Improvement in Health and Social Care

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## 1.0 Service information

<p><b>Organisation/Registered Provider:</b> Zest Investments (Portadown) Limited</p> <p><b>Registered Person</b> Mr Philip Scott</p>	<p><b>Registered Manager:</b> Mrs Patricia Purvis</p> <p><b>Date registered:</b> 8 November 2019</p>
<p><b>Person in charge at the time of inspection:</b> Mrs Patricia Purvis</p>	<p><b>Number of registered places:</b> 41</p>
<p><b>Categories of care:</b> Nursing (NH): I – old age not falling within any other category DE – dementia</p>	<p><b>Number of patients accommodated in the nursing home on the day of this inspection:</b> 39</p> <p>Including: A maximum of 19 patients in category NH-I accommodated in the Jasmine Unit and a maximum of 22 patients in category NH-DE accommodated in the Sunflower Unit.</p>
<p><b>Brief description of the accommodation/how the service operates:</b> Rosemount Care Centre is a nursing home which is registered to provide nursing care for up to 41 patients. The home is divided into two units on the first floor of the building.</p> <p>The building is occupied by a residential care home on the ground floor of the building and the registered manager is responsible for both services.</p>	

## 2.0 Inspection summary

An unannounced inspection took place on 6 August 2024, from 10.50am to 3.10pm. This was completed by a pharmacist inspector and focused on medicines management within the home. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. 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 patients were administered their medicines as prescribed.

One area for improvement identified at the last medicines management inspection had been addressed. The two areas for improvement identified at the last care inspection have been carried forward and will be followed up at the next care inspection. No new areas for improvement were identified.

Based on the inspection findings and discussions held, RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the management team regarding the management of medicines.

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

### **3.0 How we inspect**

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing 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 previous inspection findings, incidents and correspondence. The inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. Discussions took place with staff and management about how they plan, deliver and monitor the management of medicines in the home.

### **4.0 What people told us about the service**

The inspector met with three nurses, the deputy manager and the manager. 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.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no questionnaires had been received by RQIA.

## 5.0 The inspection

### 5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

Areas for improvement from the last inspection on 8 July 2024		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
<b>Area for improvement 1</b> <b>Ref:</b> Regulation 13 (4) <b>Stated:</b> First time	The registered person must review and revise the management of medicines on admission as detailed in the report.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> This area for improvement was assessed as met (see section 5.2.4).	
<b>Area for improvement 2</b> <b>Ref:</b> Regulation 20 (1) (a) <b>Stated:</b> First time	The registered person must put in place adequate hours of activity provision to meet patient' needs and dependencies.	<b>Carried forward to the next inspection</b>
	<b>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.</b>	
<b>Area for improvement 3</b> <b>Ref:</b> Regulation 27 (4) (a) <b>Stated:</b> First time	The registered person shall submit to RQIA a time bound action plan detailing how the outstanding recommendation in the fire safety risk assessment dated will be dealt with.	<b>Carried forward to the next inspection</b>
	<b>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.</b>	

## 5.2 Inspection findings

### 5.2.1 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 the GP, the 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 state that they were accurate. A couple of minor discrepancies were highlighted to nurses and addressed immediately.

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

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 clearly recorded on the personal medication records; 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. Records included the reason for and usually the outcome of each administration. Nurses were reminded to record the outcome following each administration.

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 and pain assessments 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 was reviewed. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside of the recommended range.

### **5.2.2 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.

The records inspected showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. The temperature of medicine storage areas was monitored and recorded to ensure that medicines were stored appropriately. Medicine refrigerators and controlled drugs cabinets were available for use as needed. It was agreed that inhaler spacer devices would be stored covered for infection prevention and control purposes.

Satisfactory arrangements were in place for the safe disposal of medicines. It was agreed that the storage of medicines awaiting disposal would be reviewed and that storage of the containers within locked medicine cupboards would be considered.

### **5.2.3 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 medicine administration records was reviewed and found to have been accurately completed. The 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, 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 plans. Written consent and care plans were in place when this practice occurred.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on medicines so that they could be easily audited. This is good practice.

#### **5.2.4 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 for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

#### **5.2.5 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. A couple of minor discrepancies were highlighted for monitoring.

#### **5.2.6 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. 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. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Policies and procedures were up to date and available for staff reference.

**6.0 Quality Improvement Plan/Areas for Improvement**

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	2*	0

\* The number of areas for improvement includes two which are carried forward for review at the next inspection.

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Mrs Patricia Purvis, Registered Manager, as part of the inspection process and can be found in the main body of the report.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005</b>	
<b>Area for improvement 1</b> <b>Ref:</b> Regulation 20 (1) (a) <b>Stated:</b> First time <b>To be completed by:</b> 8 September 2024	The registered person must put in place adequate hours of activity provision to meet patient’ needs and dependencies.  <b>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.</b>  Ref: 5.1
<b>Area for improvement 2</b> <b>Ref:</b> Regulation 27 (4) (a) <b>Stated:</b> First time <b>To be completed by:</b> 8 August 2024	The registered person shall submit to RQIA a time bound action plan detailing how the outstanding recommendation in the fire safety risk assessment dated will be dealt with.  <b>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.</b>  Ref: 5.1



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