The Regulation and Quality Improvement Authority

Inspection Report

28 October 2021

80 Malone Road

Type of service: Residential Care Home
Address: 80 Malone Road, Belfast, BT9 5BU
Telephone number: 028 9504 0370

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: Belfast HSC Trust **Responsible Individual:** Dr Catherine Jack (registration pending)	**Registered Manager:** Miss Fiona Campbell **Date registered:** 23 April 2018
Person in charge at the time of inspection: Miss Fiona Campbell	**Number of registered places:** 12
Categories of care: Residential Care (RC): LD – learning disability LD(E) – learning disability – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 8
Brief description of the accommodation/how the service operates: This is a residential care home which provides care for up to 12 residents living with learning disability.	

2.0 Inspection summary

An unannounced inspection took place on 28 October 2021 from 11.00am to 2.50pm. This was undertaken by a pharmacist inspector and focused on medicines management within the home. It also assessed progress with any areas for improvement identified since the last care inspection.

Review of medicines management found that residents were being administered their medicines as prescribed. Areas of good practice were acknowledged. Arrangements were in place to ensure that staff were trained and competent in medicines management. Most of the medicine records were well maintained and all medicines were stored securely. However, improvement is required in the record keeping regarding incoming medicines and administration of thickening agents.

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 reviewing a sample of medicine related records and care plans, medicines storage and the auditing systems used to ensure the safe management of medicines. Staff opinions were also obtained.

4.0 What people told us about the service

The residents could not verbally express their views on the care provided. However, they were observed to be relaxed and content in their surroundings. Festive decorations were displayed in the main lounge and dining room.

Staff interactions with residents were warm, friendly and supportive. It was evident they knew the residents well. It was acknowledged that many of the staff have worked in the home for several years and were very familiar with how the residents' would express their needs.

All staff were wearing face masks. The manager advised that other PPE was worn for personal care and as needed.

Feedback methods included a staff poster and paper questionnaires which were provided for any resident 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 completed or returned questionnaires to RQIA.

5.0 The inspection

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

Areas for improvement from the last care inspection on 23 August 2021		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 20.10 **Stated:** First time	The registered person shall ensure that care record audits are signed and dated. The action plans should also be completed to evidence that identified actions have been undertaken.	**Partially met**
	Action taken as confirmed during the inspection: The care plan audits were dated and signed by the manager. There was no evidence that any identified actions had been completed. This area for improvement is stated for a second time.	
Area for improvement 2 **Ref:** Standard 17.10 **Stated**: First time	The registered person shall ensure that the records of any complaints received includes details of all communications with complainants, the result of any investigations and the actions taken including if the complainant is satisfied with the outcome.	**Met**
	Action taken as confirmed during the inspection: The documentation used to record complaints had been revised. A sample template and a completed record were provided; review of these indicated that the necessary information had been recorded.	

5.2 Inspection findings

5.2.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times the residents' needs will 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 and hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had verified and signed the personal medication records when they were written and updated, to check that they were accurate.

Copies of residents' 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 best practice.

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, pain, modified diets, diabetes, etc. Following a review of residents' files, there was evidence that medicine related care plans were in place. Details of how pain would be expressed and managed were included in each resident's personalised care passport.

For residents who required a modified diet to ensure they received adequate nutrition, speech and language assessment reports were also in place. The prescribed fluid consistency level was clearly highlighted on the personal medication records; details were also displayed in the kitchen area for staff reference. The good practice of adding the resident's photograph to each prescribed diet plan was acknowledged. However, when thickening agents were administered, this was not recorded. This was discussed and advice given; an area for improvement was identified.

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

Medicines 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.

The records inspected showed that medicines were available for administration when residents required them. Staff advised that they worked closely with each resident's GP and the community pharmacist to ensure that medicines are supplied in a timely manner. It was noted that when medicines were supplied in the monitored dosage system, the date of receipt was not routinely recorded. Also, details of a small number of incoming medicines had not been recorded in the receipt records. An area for improvement was identified.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were clean, tidy and well-organised so that medicines belonging to each resident could be easily located. A controlled drugs cabinet was available for use as needed. Only one medicine required cold storage and this was being managed appropriately.

Discontinued medicines were safely returned to the community pharmacy for disposal and records maintained.

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 residents to ensure that they are receiving the correct prescribed treatment.

Review of a sample of the medicine administration records (MARs) evidenced that they had been well maintained and indicated that overall, residents had received their medicines as prescribed. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. Systems were in place to ensure that these records were filed appropriately each month.

The manager was responsible for completing the medicine management audits. These were completed at least monthly. Areas to improve on were shared with staff for their learning and followed up at supervision sessions with staff. In line with best practice, the date of opening was recorded on medicines so that they could be easily audited.

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.

The admission process for residents new to the home or returning to the home after receiving hospital care was reviewed. There had been no recent admissions to the home. Staff advised that robust arrangements were in place to ensure that they were provided with written confirmation of the resident's list of medicines from the hospital or GP and systems were in place to follow up on any discrepancies noted in a timely manner.

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 auditing system will help to identify medicine related incidents.

The medicine related incidents reported to RQIA since the last medicines inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

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

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

There were records in place to show that staff were trained and deemed competent in medicines management. Additional training in epilepsy awareness and the administration of buccal midazolam had been completed by designated staff.

6.0 Conclusion

The outcome of this inspection concluded that the residents were being administered their medicines as prescribed. Robust systems were in place to audit and monitor medicines.

However, two new areas for improvement in relation to record keeping have been identified. One of the two areas for improvement identified at the last inspection was validated as met; and one will be stated for a second time.

Based on the inspection findings and discussions held we 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 manager with respect to medicines management.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with Minimum Standards for Residential Care Homes (April 2011).

	Regulations	Standards
Total number of Areas for Improvement	0	3*

* the total number of areas for improvement includes one that has been stated for a second time

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Fiona Campbell, 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 Residential Care Homes Minimum Standards (2021)	
Area for Improvement 1 **Ref:** Standard 20.10 **Stated:** Second time **To be completed by:** Immediately and ongoing	The registered person shall ensure that care record audits are signed and dated. The action plans should also be completed to evidence that identified actions have been undertaken. Ref: 5.1
	Response by registered person detailing the actions taken: The registered person shall ensure the care record audits have been signed and dated and this was in place. The Action plans have been reviewed to ensure identified actions have been completed.
Area for improvement 2 **Ref:** Standard 31 **Stated:** First time **To be completed by:** Immediately and ongoing	The registered person shall review the administration of thickening agents, to ensure that records clearly indicate the fluid consistency prescribed and when they are administered. Ref: 5.2.1
	Response by registered person detailing the actions taken: The registered person has implemented a process which requires staff to sign when thickening agents have been added to medication or fluids and to confirm that all of these are thickened to the prescribed consistency. This will be monitored through training and supervision.
Area for improvement 3 **Ref:** Standard 31 **Stated**: First time **To be completed by:** Immediately and ongoing	The registered person shall ensure that detailed records of all incoming medicines are maintained. Ref: 5.2.2
	Response by registered person detailing the actions taken: The registered person has now implemented a process to ensure the date of receipt of incoming medications is recorded. This will be monitored through medication audits and checks.

Please ensure this document is completed in full and returned via the Web Portal

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