The Regulation and Quality Improvement Authority

Inspection Report

16 November 2021

Belvedere

Type of service: Residential Care Home
Address: 63 Gilford Road, Lurgan, Craigavon, BT66 7EA
Telephone number: 028 3832 5709

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: Belvedere Residential Care Ltd **Responsible Individual:** Ms Aisling McShane	**Registered Manager:** Mrs Catherine McConville **Date registered:** Not registered – registration pending
Person in charge at the time of inspection: Mrs Sara Anderson, Deputy Manager	**Number of registered places:** 21
Categories of care: Residential Care (RC): DE – dementia I – old age not falling within any other category LD(E) – learning disability – over 65 years MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 17
Brief description of the accommodation/how the service operates: This is a residential care home which provides care for up to 21 residents.	

2.0 Inspection summary

An unannounced inspection took place on 16 November 2021 from 10.30am to 2.30pm. It was completed by a pharmacist inspector and focused on medicines management within the home.

The two areas for improvement identified at the last care inspection will be reviewed at the next care inspection.

Review of medicines management found that residents were being administered their medicines as prescribed. Arrangements were in place to ensure that staff received training and were deemed competent in medicines management. All medicines were stored securely.

However, the inspection findings indicate that the governance arrangements for medicines management require review, as improvement is necessary in the standard of record keeping.

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 we reviewed information held by RQIA about this home. This included previous inspection findings, incidents and correspondence. To complete the inspection we reviewed: a sample of medicine related records and care plans, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines.

4.0 What people told us about the service

Residents were observed to be relaxing in the lounge watching television. Staff were warm, friendly and supportive. It was evident from their interactions that they knew the residents well.

We met with the deputy manager and one other member of staff. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Feedback methods included a staff poster and paper questionnaires which were provided to the deputy manager for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes.

At the time of issuing this report, four questionnaires had been received by RQIA; the responses indicated that the residents were "very satisfied" with the care provided in the home.

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 inspection on 14 June 2021		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 27.(2).(t) **Stated:** First time	The registered person shall ensure the environment is managed in such a way to reduce risk from hazards. Reference to this includes ensuring safe storage of hazardous substances.	**Carried forward to the next inspection**
	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.	
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 6 **Stated:** First time	The registered person shall ensure care plans are regularly reviewed and updated on a consistent basis.	**Carried forward to the next inspection**
	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.	

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 the GP, the 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.

It was identified that these records were not up to date with the most recent prescription and some were incomplete. On a few occasions, there were duplicated entries for the same medicine, new medicines were not added and there were amended entries. A small number of new entries were not signed by two staff, this is necessary to check the accuracy of the information. A line had not been drawn through the entire entry when medicines were discontinued. The personal medication records must be kept up to date at all times, as if not, this could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff did not use these records as part of the administration of medicines process. An area for improvement was identified.

Copies of residents' prescriptions are retained in the home and staff confirmed that they are used to check that all prescribed medicines are available for administration. We acknowledged that overall medicines were available and being administered accurately. It was reiterated that staff should use these prescriptions to cross reference with the resident's personal medication record to ensure accuracy.

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, self-administration etc.

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 on 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 the management of distressed reactions was reviewed. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour and were aware that this change may be associated with pain. For one resident, the medicine dosage was clearly recorded on the personal medication record and a care plan was in place. The reason for and outcome of administration were recorded on some, but not all occasions. It was agreed that this would be closely reviewed within the audit process. In relation to another resident, their personal medication record had not been updated to reflect a change in the prescription. The correct dose was being administered.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required. Pain management was included in the residents' care plans.

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 each 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 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 organised so that medicines belonging to each resident could be easily located. A medicine refrigerator and controlled drugs cabinet were available for use as needed. Staff were reminded that the controlled drug cabinet should be used solely for the storage of controlled drugs. It was agreed that the non-medicinal items would be removed after the inspection.

Discontinued medicines were 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.

The administration of medicines was recorded on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. The sample of these records reviewed indicated that they had not been fully and accurately completed. When handwriting these records, two staff were involved in some but not all occasions; this is necessary to check the accuracy of information being written. The printed dates on a number of the current MARs were incorrect and resulted in staff overwriting the dates; this had led to recording errors. In addition, several MARs did not correlate with the corresponding personal medication records. (See Section 5.2.1.) The personal medication records are a record of the prescribed medicines, the MARs are a record of the medicines administered. These records must match to ensure that medicines are being administered to residents as prescribed. A system should be in place to ensure both records are checked at each change of the medicine cycle to ensure correlation. Two areas for improvement were made.

In relation to topical medicines administered by care staff, it was established that senior staff signed the records of administration. The staff member preparing and administering a medicine must sign the administration records. This was discussed and advice given. An area for improvement was identified.

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 are recorded in a controlled drug record book. A number of amended entries were noted and resulted in overwriting; entries in medicine records should not be amended. An area for improvement was identified.

Management and staff audited medicine administration on a regular basis and records were maintained. Their audits were focused mainly on tablets and capsules and did not routinely include other formulations of medicines, such as inhalers, liquids, eye preparations, and insulin. The date of opening was recorded on most but not all medicines; this should be recorded on all medicines to assist with audit. One expired medicine was removed from stock.

The audits completed at the inspection indicated that the majority of medicines were administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. A review of the monthly management audits indicated that the issues raised at this inspection were not being identified. The audit process should be developed to ensure that it is covers all aspects of medicines management and administration and is effective at identifying shortfalls in the medicines systems. An area for improvement was made.

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 management of medicines for new residents or residents returning to the home after receiving hospital care was reviewed. Written confirmation of the resident's current medicine regime had been obtained. Systems were in place to inform the community pharmacy of any medication changes. The need for the personal medication records to be accurately written/rewritten was reiterated. See Section 5.2.1.

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 staff to identify medicine related incidents.

A review of the reported incidents indicated that staff were aware when a medicine incident had occurred. These were reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

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 reference.

Arrangements were in place to review staff training and competency in medicines management. A sample of these records was provided at inspection. The deputy manager advised that the issues raised at this inspection would be shared with the registered manager and highlighted at the upcoming staff meeting (17 November 2021).

Medicine management policies and procedures were in place.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

Overall there was evidence that the residents were administered their medicines as prescribed. The outcome of this inspection concluded that improvements in some areas of medicines management are necessary to ensure that robust arrangements are in place. A review of the current auditing process to ensure that this covers all aspects of medicines will assist management and staff in addressing the areas for improvement identified. This inspection resulted in six new areas for improvement.

We would like to thank the staff for their assistance with the inspection.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Residential Care Home Regulations (Northern Ireland) 2005 and the Residential Care Homes Minimum Standards (August 2021 version 1.1).

	Regulations	Standards
Total number of Areas for Improvement	4*	4*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Sara Anderson, 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 Residential Care Home Regulations (Northern Ireland) 2005	
Area for Improvement 1 **Ref:** Regulation 27.(2).(t) **Stated:** First time **To be completed by:** 14 June 2021	The registered person shall ensure the environment is managed in such a way to reduce risk from hazards. Reference to this includes ensuring safe storage of hazardous substances. **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.** Ref: 5.1
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 16 December 2021	The registered person shall ensure that personal medication records are fully and accurately maintained at all times. Ref: 5.2.1 **Response by registered person detailing the actions taken:** This was communicated to all staff responsible at the staff meeting and management is ensuring compliance through auditing
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 16 December 2021	The registered person shall ensure that medication administration records are fully and accurately maintained at all times. Ref: 5.2.3 **Response by registered person detailing the actions taken:** The auditing tool was reviewed and improved to ensure the accuracy of records is checked regularly. Staff are trained and are aware of the importance of full and accurate records.
Area for improvement 4 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 16 December 2021	The registered person shall develop and implement a robust auditing system for medicines management which covers all aspects of medicines management. Ref: 5.2.3 & 5.2.5 **Response by registered person detailing the actions taken**: The auditing tool was reviewed and improved and now covers all medicine types including inhalers, eye drops, supplements and insulin.

Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2021 version 1.1)	
Area for Improvement 1 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 21 June 2021	The registered person shall ensure care plans are regularly reviewed and updated on a consistent basis. **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: 5.1
Area for improvement 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 16 December 2021	The registered person shall review the process to manage recording errors and updates to ensure medicine entries are not amended or overwritten. Ref: 5.2.1 & 5.2.3 **Response by registered person detailing the actions taken:** All staff are now aware that medicine entries are not ammended or overwritten
Area for improvement 3 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 16 December 2021	The registered person shall ensure that two staff are involved in the writing and updating of personal medication records and medication administration records; both staff should sign the records and ensure that each resident's records correlate. Ref: 5.2.1 & 5.2.3 **Response by registered person detailing the actions taken:** This has been communicated and understood by all staff. This is reiterated in their staff training and supervisions.
Area for improvement 4 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 16 December 2021	The registered person shall review the process for recording the administration of topical medicines; records of administration must be completed by the person who administered the medicine. Ref: 5.2.3 **Response by registered person detailing the actions taken:** The policy on Topical medicines has been reviewed and updated. Body maps and Topical Medicine Administration Chart is now used for staff to complete after they have applied a topical medicine.

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

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