The Regulation and Quality Improvement Authority

Inspection Report

18 October 2022

Cedarhurst Lodge

Type of service: Residential Care Home
Address: Cedar Suite, Cedarhurst Road, Belfast, BT8 7RH
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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: Electus Healthcare 1 Limited **Responsible Individual:** Mr Edmund Coyle	**Registered Manager:** Mrs Julie-Ann Jamieson (Registration pending)
Person in charge at the time of inspection: Mrs Julie-Ann Jamieson	**Number of registered places:** 24 This number includes: RC-DE for a maximum of four persons and RC-MP / RC-MP (E) for a maximum of 20 persons.
Categories of care: Residential Care (RC): DE – dementia 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:** 23
Brief description of the accommodation/how the service operates: This is a residential care home that provides care for up to 24 residents living with dementia or mental ill-health. The residential care home is on the same site as a nursing home.	

2.0 Inspection summary

An unannounced inspection took place on 18 October 2022, from 10.10am to 2.00pm. This was completed by a pharmacist inspector.

The inspection 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.

One area for improvement identified at the last care inspection has been assessed as met and the second area for improvement identified at the last care inspection will be followed up at the next care inspection.

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan and include the safe disposal of medicines, maintaining accurate personal medication records and ensuring care plans are in place for the management of pain.

Whilst areas for improvement were identified, RQIA can conclude that overall, with the exception of a small number of medicines, the residents were being administered their medicines as prescribed.

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. Staff and residents views were also sought.

4.0 What people told us about the service

The inspector met with senior care staff, the manager and the operations manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well. Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs.

Feedback methods included a staff poster and paper questionnaires which were provided to the 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, 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 care inspection on 13 September 2022		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 13 (4) (c) **Stated:** Second time	The registered person shall ensure an accurate written record is kept of the administration of topical creams to a resident.	**Met**
	Action taken as confirmed during the inspection: Records were reviewed for two residents. An accurate record was completed for the administration of topical creams by care assistants for both residents.	
Action required to ensure compliance with the Residential Care Homes Minimum Standards (2021)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 6.6 **Stated:** First time	The registered person shall ensure that all resident care plans are kept up to date and reflective of resident's current needs.	**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 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.

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 at the inspection were not all accurate and up to date with the most recent prescription. 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/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.

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. However care plans were not in place. An area for improvement was identified.

The management of insulin was reviewed for three residents. Care plans were in place when residents required insulin to manage their diabetes. There was sufficient detail in the care plan to direct staff if the resident's blood sugar was outside 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?

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 had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines 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. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

In residential care homes all medicines for disposal must be returned to the pharmacy for safe disposal. The medicines disposal book reviewed had records of medicines, including controlled drugs that had been destroyed/denatured in the home. In residential care homes controlled drugs should not be denatured. The manager advised that this practice would cease from the date of the inspection. The Standard Operating Procedure for the return/disposal of all medicines including controlled drugs should be reviewed and updated. An area for improvement was identified.

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.

A sample of the medicines administration records was reviewed. All of the records reviewed were found to have been fully and accurately completed. The records were filed once completed.

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 receipt and administration of controlled drugs. An area for improvement has already been identified regarding the safe disposal of medicines (see section 5.2.2).

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out including running balances of boxed medicines and a monthly management audit covering all aspects of medicines management. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, an audit discrepancy was observed in the administration of one medicine which was highlighted to the manager for immediate action.

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 two residents who had a recent hospital stay and were discharged to this home was reviewed. Hospital discharge letters had been received and a copy had been forwarded to the residents' GPs. However, for one resident their personal medication records had not been completed accurately to reflect the prescribed dose of one medicine. An area for improvement has already been identified regarding maintaining accurate personal medication records (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 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 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 they are supported.

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.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes (Northern Ireland) 2005 and Residential Care Homes Minimum Standards 2021.

	Regulations	Standards
Total number of Areas for Improvement	1	3*

* The total number of areas for improvement includes one that is carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Julie-Ann Jamieson, 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:** Immediate and ongoing	The registered person shall ensure that accurate and up to date personal medication records are written and maintained for all residents including new admissions to the home. Ref: 5.2.1
	Response by registered person detailing the actions taken: Personal medication records are confirmed with records obtained from GP/hospital at point of admission. Record maintained monthly using prescriptions received with each monthly script and acute.
Action required to ensure compliance with the Residential Care Homes Minimum Standards 2021	
Area for improvement 1 **Ref:** Standard 6.6 **Stated:** First time **To be completed by:** With immediate effect (13 September 2022)	The registered person shall ensure that all resident care plans are kept up to date and reflective of resident's current needs.
	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 6 **Stated:** First time **To be completed by:** Immediate and ongoing (18 October 2022)	The registered person shall review the management of medicines prescribed for pain to ensure there is a care plan in place to direct staff. Ref: 5.2.1
	Response by registered person detailing the actions taken: The required need for analgesia is detailed in individuals care plan. This discusses the drug, its usage and maximum dosage for reference.
Area for improvement 3 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 15 November 2022	The registered person shall review and update the Standard Operating Procedure for the return/disposal of medicines. Ref: 5.2.2
	Response by registered person detailing the actions taken: Medications which are not required are returned to pharmacy. They are no longer destroyed within the home. Standard operating procedure updated and available for viewing.

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

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