The Regulation and Quality Improvement Authority

Inspection Report

9 September 2021

Trench Park

Type of Service: Residential Care Home
Address: 28 Trench Park, Belfast, BT11 9FG
Tel no: 028 9504 3990

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 Health and Social Care Trust (BHSCT) **Responsible Individual:** Dr Catherine Jack	**Registered Manager:** Mrs Victoria McQuoid – registration pending
Person in charge at the time of inspection: Mrs Victoria McQuoid	**Number of registered places:** 2
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:** 0
Brief description of the accommodation/how the service operates: This home is registered as a residential care home and provides social care for up to two residents with a learning disability. The home offers short stay respite care. The home is adjacent to the Trench Park Centre, a supported living facility for service users with a learning disability.	

2.0 Inspection summary

An unannounced inspection took place on 9 September 2021, between 10.30 am and 1.15 pm. The inspection was conducted by a pharmacist inspector and focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified since the last care inspection. Following discussion with the aligned care inspector, it was agreed that two of the four areas for improvement identified at the last inspection would be followed up at the next care inspection.

Review of medicines management found that residents were being administered their medicines as prescribed. There were arrangements for auditing medicines and medicine records were well maintained. Arrangements were in place to ensure that staff were trained and competent in medicines management.

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. To complete the inspection the following were reviewed: a sample of medicine related records, 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

We met with two members of staff and the manager.

There were no residents as the home was undergoing significant improvement works. The most recent resident was discharged in July 2021 and it was hoped the next admission will take place towards the end of September 2021.

Staff were warm and friendly and it was evident from discussions that they knew the regular short stay residents well. Staff were wearing face masks as needed. PPE signage was displayed.

The staff members spoken with expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager to provide to any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no feedback 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 June 2021		
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 18 **Stated:** Second time	The Registered Person shall ensure that the pre-admission assessment documents include a record of discussions regarding DOL safeguards.	**Met**
	Action taken as confirmed during the inspection: Three of the most recent pre-admission records were examined. It was evident that a discussion regarding DOL safeguards had taken place and the relevant documents were on file. The manager advised this has been incorporated into the pre-admission checklist and documentation had been requested for all regular users of the respite service.	
Area for improvement 2 **Ref:** Standard 20.2 **Stated:** First time	The Registered Person shall ensure that records to assist the Manager in monitoring staff compliance with the completion of training are kept up to date.	**Met**
	Action taken as confirmed during the inspection: A training matrix had been put into place which contained records of all training dates and expected intervals. Any training overdue was highlighted using a colour coded system. Information was added from paper records on an ongoing basis by the administrative assistant. Significant progress has been made and mandatory training and medicines management training was recorded.	

Area for improvement 3 **Ref:** Standard 25.6 **Stated:** First time	The Registered Person shall ensure that the duty rota includes all staff working daily. **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.**	**Carried forward to the next inspection**
Area for improvement 4 **Ref:** Standard 8.5 **Stated:** First time	The Registered Person must ensure that care records are signed by the person completing them. **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.**	**Carried forward to the next inspection**

No areas for improvement were identified at the last medicines management inspection on 5 May 2017.

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.

Personal medication records (PMRs) 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 e.g. medication reviews, hospital appointments.

Since this is a respite service, residents were registered with their family GP and a PMR was kept on file for each resident. Arrangements were in place for the safe management of medicines at each period of respite care. Personal medication record entries were usually signed by the resident's general practitioner or by two members of trained staff. Staff advised of the procedures in place to manage any changes during each period of respite care. Staff were reminded that the resident's date of birth should be recorded on every PMR.

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 etc.

The management of medicines prescribed on a "when required" basis for the management of distressed reactions, pain and seizures 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. Directions for the use of "when required" medicines were recorded on the personal medication records and in the care plan and epilepsy management plan where applicable.

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 staff must ensure enough stock is received for each period of respite care. 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.

There were no residents accommodated in the home at the time of the inspection and there were no medicines held in stock. Lockable cupboards were available for the safe storage of medicines. A refrigerator was available for medicines which required cold storage.

Discontinued or expired medicines were managed appropriately. Medicines remaining at the end of each period of respite care were returned to the resident's family/representative. Records were maintained, however the record had not been fully completed on one occasion. Staff were reminded that this information must be recorded to ensure a clear audit trail.

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 medicine administration records (MARs) records was reviewed. Most of the records were found to have been fully and accurately completed. One administration had not been recorded and this was highlighted to staff for attention.

Staff audited medicine administration at the end of each stay to check that medicines had been administered as prescribed.

Residents may have their medicines administered in food/drinks to assist administration. Care plans detailing how the residents like to take their medicines were in place.

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.

There had been no recent admissions to the home. However, the admission process for residents new to the home was discussed. From the information provided by staff, RQIA is assured that robust arrangements were in place to check current medicine regimes with the resident's representative and when necessary, obtain a list of current medicines from the resident's GP.

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.

The audit system in place helps 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 that they are supported. Policies and procedures should be up to date and readily available for staff use.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. The manager stated that competency assessments were due to be updated prior to admissions restarting. Trust policy and procedure documents were in place. The manager agreed to check if a more recent edition was available, since the document in place was due for review in June 2021.

Records of staff training in relation to medicines management, epilepsy awareness and buccal midazolam were available.

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 regarding the management of medicines.

RQIA was assured that the residents were being administered their medicines as prescribed. No new areas for improvement were identified.

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

7.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	2*

*the total 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 Vicki McQuoid, Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan	
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 25.6 **Stated:** First time **To be completed by:** 7 June 2021	The Registered Person shall ensure that the duty rota includes all staff working daily. **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 8.5 **Stated:** First time **To be completed by:** 7 June 2021	The Registered Person must ensure that care records are signed by the person completing them. **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

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