The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Mertoun Park

Provider: Belfast Health and Social Care Trust

Date of Inspection: 29 May 2025

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
Responsible Individual:	Mrs Maureen Edwards
Registered Manager:	Ms Danielle Lennon
Service Profile: Mertoun Park is a residential care home registered to provide health and social care for up to eight residents living with a learning disability. The home is divided over two floors. There are a range of communal areas throughout the home and residents have access to an enclosed garden.	

2.0 Inspection summary

An unannounced inspection took place on 29 May 2025, from 9.50am to 12.30pm. The inspection was completed by two pharmacist inspectors and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Review of medicines management found that satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and the majority of 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 residents were administered their medicines as prescribed. No new areas for improvement were identified.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, can be found in the main body of this report and in the Quality Improvement Plan (QIP) (Section 4.0).

We spoke with one resident who said that they were very happy with the care provided and enjoyed being in the home.

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

3.0 The inspection

3.1 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from residents, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

3.2 What people told us about the service and their quality of life

We spoke with one resident who said that they enjoyed staying in Mertoun Park. Staff advised that the resident enjoyed regular outings.

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after residents and meet their needs. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise. Staff highlighted a number of improvements which had been implemented since the last medicines management inspection. These included the new template for personal medication records, the auditing system and the new medicine cupboards.

Staff advised that they were familiar with how each resident liked to take their medicines and medicines were administered in accordance with individual resident preference.

RQIA did not receive any responses to the staff surveys or questionnaires from residents and families.

3.3 Inspection findings

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

Residents in residential care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times residents' needs may 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 a community pharmacist. Residents bring their own medicines with them at the start of their stay and any unused medicines are returned at the end of the stay.

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.

Staff have access to Northern Ireland Electronic Care Records so that entries on the personal medication records can be checked against the most recent prescription. The personal medication records reviewed were accurate and up to date. In line with best practice, a second member of staff had checked the personal medication records when they were written and updated to confirm that they were accurate. However, a number of the personal medication records had not been signed by both staff. The manager advised that this had been identified through the audit process and discussed at the recent team meeting for corrective action.

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, epilepsy 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 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 distressed reactions, was reviewed for two residents. The medicines were used infrequently and staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain and other factors. Directions for use were clearly recorded on the personal medication records and staff advised that records of administration included the reason for and outcome of each administration. Resident-centred care plans were put in place immediately following the inspection.

Some residents may require the administration of emergency medicines to treat seizures or allergic reactions. There were care plans in place to direct staff in the administration of these medicines and evidence that staff had received the appropriate training.

3.3.2 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 at admission to ensure that residents have enough stock to cover their short stay. It is important that they are stored safely and securely so that there is no unauthorised access and returned to the resident/family promptly at the end of the stay.

Records reviewed showed that medicines were available for administration when residents required them. Staff advised that they discuss medicines as part of the pre-admission assessment and any shortfalls are followed up to ensure that residents do not miss doses of their prescribed medicines.

The medicines storage area was observed to be securely locked to prevent any unauthorised access. Storage 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.

Staff advised that residents were not prescribed any medicines requiring cold storage and that a medicines refrigerator was available if necessary.

Controlled drugs were observed to be stored securely in a controlled drug cupboard.

Satisfactory arrangements were in place for the return of medicines at the end of each stay.

3.3.3 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, the records had had been accurately completed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. The receipt, administration and disposal of controlled drugs were recorded in a controlled drug record book. As identified at the last medicines management inspection, some entries for medicines received had been duplicated and when medicines were returned, the balance was not always brought to zero. This was discussed in detail with the manager and staff on duty. The manager advised that staff would receive further training and the standard of maintenance of the controlled drug record book would be closely monitored through the audit process.

In addition to the daily stock counts completed by staff, the manager completed a weekly audit which included all aspects of medicines management. There was evidence that action was

taken if shortfalls were identified. The audits completed at the inspection indicated that medicines were being administered as prescribed.

3.3.4 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 at the time of admission for each stay. As detailed in Section 3.3.1 staff have access to a current list of each resident's medicines via the Northern Ireland Electronic Care Record.

3.3.5 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.

3.3.6 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 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.

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.

Records of staff training and competency assessment were available in relation to medicines management, epilepsy awareness including the administration of buccal midazolam and the administration of adrenaline to treat allergic reactions.

It was agreed that staff would receive further training on record keeping for controlled drugs.

4.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	3*	2*

* Five areas for improvement were 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 Ms Danielle Lennon, Registered 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 The Residential Home Regulations (Northern Ireland) 2005	
Area for Improvement 1 **Ref:** Regulation 27 (4) (f) **Stated:** First time **To be completed by:** 18 April 2025	The registered person shall ensure that all staff complete fire drills. **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: 2.0
Area for improvement 2 **Ref:** Regulation 27 (4) (c) (d) (i) **Stated:** First time **To be completed by:** 9 April 2025	The registered person shall ensure that the practice of propping open of fire doors ceases immediately. **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: 2.0
Area for improvement 3 **Ref:** Regulation 27 (4) (a) **Stated:** First time **To be completed by:** 10 April 2025	The registered person shall ensure the following in regard to fire safety arrangements: The fire risk assessment is effectively maintained by the manager and evidences any actions taken in regard to the recommended actions required. **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: 2.0
Action required to ensure compliance with the Care Standards for Residential Homes, December 2022	
Area for Improvement 1 **Ref:** Standard E8 **Stated:** Second time **To be completed by:** 1 July 2024	The registered person shall review the home and ensure that call points accessible to residents are provided in every room that is used by residents **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: 2.0

Area for improvement 2 **Ref:** Standard 25 **Stated:** First time **To be completed by:** 10 April 2025	The registered person shall ensure that the staff duty rota is maintained in keeping with legislation and best practice guidance.
	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: 2.0

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