Unannounced Medicines Management Inspection Report
9 February 2017

Home Treatment House

Type of Service: Nursing Home
Address: Old See House, 603 Antrim Road, Belfast, BT15 4DX
Tel no: 028 9504 2873
Inspector: Helen Daly

1.0 Summary

An unannounced inspection of Home Treatment House took place on 9 February 2017 from 11.45 to 14.20.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines were trained and competent. It was evident that the working relationship with the community team, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. However one area for improvement was identified in relation to the disposal of medicines and a requirement was made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. There were no areas for improvement identified.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for patients. Patients consulted with confirmed that they were administered their medicines appropriately. There were no areas for improvement identified.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. There were no areas for improvement identified.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	0

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mr Kevin Mackel, Acting Manager, as part of the inspection process. Details were also discussed with Miss Domenica Gilroy, Registered Manager, via telephone call on 21 February 2017. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most care recent inspection on 6 January 2017.

2.0 Service details

Registered organisation/registered person: Belfast HSC Trust Mr Martin Joseph Dillon	**Registered manager:** See below
Person in charge of the home at the time of inspection: Mr Kevin Mackel	**Date manager registered:** Mr Kevin Mackel Acting – No application required
Categories of care: NH-MP, NH-MP(E)	**Number of registered places:** 6

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection.

We met with one patient, one registered nurse and the acting manager.

A number of questionnaires were issued to patients, relatives/representatives and staff, with a request that they were returned within one week from the date of the inspection.

A sample of the following records was examined during the inspection:

- medicines received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- policies and procedures
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 6 January 2017

The most recent inspection of the home was an unannounced care inspection. The returned QIP will be assessed and approved by the care inspector. This QIP will be validated by the care inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection on 10 February 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 37 **Stated:** First time	The responsible individual should ensure that the medicine policy and standard operating procedures reflect the procedures within the home.	**Met**
	Action taken as confirmed during the inspection: Policies and procedures for the management of medicines were in place. They were being reviewed and revised frequently to ensure that they reflected the procedures within the home.	
Recommendation 2 **Ref:** Standard 37 **Stated:** First time	The responsible individual should introduce a medicine auditing system and ensure it covers all aspects of the management of medicines.	**Met**
	Action taken as confirmed during the inspection: Medication audits were completed when patients were discharged from the home. In addition the registered manager completed spot checks.	

4.3 Is care safe?

The acting manager advised that medicines were managed by staff who have been trained and deemed competent to do so. He confirmed that training on the home's systems was provided during induction for both bank and permanent staff. The impact of training was monitored through the audit process. It was agreed that records of the competency assessments would be maintained. A list of registered nurses who had completed training was available on the medicines file. The date of training was detailed.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and discharge from the home. Prescribed medicines were confirmed by accessing the electronic care records (ECR) system held at the general practitioners surgeries. The ECR was printed off and checked against the medicines supplied by patients/their representatives at admission. Any discrepancies were referred to the community team for confirmation. Personal medication records were checked and verified by two registered nurses.

There were satisfactory arrangements in place to manage changes to prescribed medicines. The majority of personal medication records and handwritten entries on medication administration records were updated by two registered nurses. This safe practice was acknowledged.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines.

Controlled drugs subject to record keeping requirements were not currently prescribed. A review of previous records indicated that records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements had been maintained in a satisfactory manner and that checks had been performed on controlled drugs at the end of each shift.

There was evidence that discontinued medicines, including controlled drugs in Schedule 4 (Part 1) were being returned to community pharmacies for disposal. This is inappropriate and had been discussed at the last medicines management inspection. The registered provider must ensure that all medicines, including controlled drugs, are disposed of in accordance with legislative requirements. A requirement was made.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. The maximum, minimum and current temperatures of the medicines refrigerator were being monitored each day. Some temperatures outside the accepted range (2^{o}C -8^{o}C) were observed and the consistent readings indicated that the thermometer was not being reset each day. Guidance on resetting the thermometer was provided to the acting manager who agreed to inform all designated staff. A requirement was not made as there were no medicines requiring refrigeration.

Areas for improvement

The registered provider must ensure that all medicines, including controlled drugs, are disposed of in accordance with legislative requirements. A requirement was made.

Number of requirements	1	**Number of recommendations**	0

4.4 Is care effective?

The majority of medicines examined had been administered in accordance with the prescriber's instructions.

The acting manager was requested to investigate one audit discrepancy whereby a medicine which was prescribed to be administered three times a day had only been administered once daily for five days. The investigation was completed and it was confirmed that the patient had been refusing the medicine. The registered manager advised that the procedure for recording medication refusals had been discussed with registered nurses for improvement.

The acting manager was reminded that bisphosphonate medicines should be administered in accordance with the manufacturer's guidance and that records of administration should reflect this practice.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour. The reason for and the outcome of administration were recorded. The registered manager confirmed that detailed care plans directing the use of "when required" medicines were in place.

Medicine records were well maintained and facilitated the audit process. The acting manager was reminded that obsolete personal medication records should be cancelled and archived.

The acting manager advised that each patient's medicines were audited at discharge. It was suggested that dates of opening should be recorded on medicines containers to facilitate the audit process.

Following discussion with the acting manager, it was evident that when applicable, other healthcare professionals are contacted in response to medication related issues.

Areas for improvement

Number of requirements	0	**Number of recommendations**	0

4.5 Is care compassionate?

We observed the administration of medicines to one patient. It was completed in a caring manner with the patient being given time to take their medicines. The medicines were administered as discreetly as possible.

We spoke with one patient who advised that she had received excellent care in the home. She used the following phrases: "staff are absolutely brilliant, I couldn't praise the staff enough, they just listen to you and help you, the food is brilliant, staff just sit with you and have meals with you, I've just got so much better."

Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

As part of the inspection process 15 questionnaires were issued to patients, relatives/ representatives and staff, with a request that they were returned within one week from the date of the inspection. Two relatives and four members of staff returned the questionnaires within this timescale. All responses indicated that they were "very satisfied".

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. The registered manager advised that they were being reviewed frequently as improvements in practice were being identified during the audit process. Registered nurses were informed of any updates.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the acting manager and one registered nurse, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff either individually or via team meetings.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Miss Domenica Gilroy, Registered Manager, and Mr Kevin Mackel, Acting Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and the Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 11 March 2017	The registered provider must ensure that all medicines, including controlled drugs, are disposed of in accordance with legislative requirements. **Response by registered provider detailing the actions taken:** FURTHER TO INSPECTION ON 9. FEBRUARY 2017 MEDICATION POLICY AMENDED AND ALL STAFF INFORMED OF CORRECT DISPOSAL PROCEDURE FOR DISUSED (INCLUDING CONTROLLED) MEDICATIONS, DENATURING KITS INSITU AND ESTATES CONTACTED TO PROVIDE LOCKABLE CUPBOARD FOR STORAGE OF BURN BOX.

Please ensure this document is completed in full and returned via web portal

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