Inspection Report
25 January 2021

Home Treatment House

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

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 this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a nursing home which is registered to provide care for up to six patients.

2.0 Service details

Organisation/Registered Provider: Belfast Health and Social Care Trust **Responsible Individual:** Dr Catherine Jack, registration pending	**Registered Manager and date registered:** Ms Sharon Casement, registration pending
Person in charge at the time of inspection: Ms Sharon Casement, Manager	**Number of registered places:** 6
Categories of care: Nursing (NH): MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years	**Total number of patients in the nursing home on the day of this inspection:** 3

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 25 January 2021 from 11.00 to 13.10.

This inspection focused on medicines management within the home. Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last care inspection would be followed up at the next care inspection.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drug records
- governance and audit
- staff training and competency records
- medicine storage temperatures
- RQIA registration certificate

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	2*

*The total number of areas for improvement includes two under the Standards which were carried forward for review at the next care inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Sharon Casement, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

5.0 What has this home done to meet any areas for improvement identified at the last medicines management inspection (11 July 2018) and the last care inspection (3 November 2020)?

No areas for improvement were identified at the last medicines management inspection.

Areas for improvement from the last care inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time	The registered person shall ensure that patients' care plans are reviewed in a meaningful and timely manner; the care plans should also evidence collaboration and agreement with patients with regard to the content of the care plan. **Action required to ensure compliance with this Standard was not reviewed as part of the inspection. This will be carried forward for review at the next care inspection.**	**Carried forward to the next care inspection**
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that risk assessments and care plans are current, individualised and reflective of identified needs. Additionally, staff should be adequately trained in developing care plans. **Action required to ensure compliance with this Standard was not reviewed as part of the inspection. This will be carried forward for review at the next care inspection.**	**Carried forward to the next care inspection**

6.0 What people told us about this home?

In order to reduce footfall in the home we remained in the manager's office and treatment room during the inspection. Therefore, we did not meet with any patients.

Staff were warm and friendly and it was evident from the discussions that they knew the patients well.

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

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any patient 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.

7.0 Inspection Findings

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

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs will 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.

Patients in Home Treatment House were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all 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.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to provide a double check that they were accurate.

All patients 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.

Patients 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 patient's distress and if the prescribed medicine is effective for the patient.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Directions for use were clearly recorded on the personal medication records. Records of administration were clearly recorded. The reason for and outcome of administration were recorded in the daily progress notes.

The management of pain was discussed. Staff advised that patients were able to tell them when they were in pain and that pain relief was administered when required. None of the patients required regular pain relief.

7.2 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 patient'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 patients 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 tidy and organised so that medicines belonging to each patient could be easily located. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory systems were in place for the disposal of medicines. Staff advised that controlled drugs in Schedules 2, 3 and 4 Part (1) were denatured prior to disposal. A second trained member of staff witnessed the disposal of medicines.

7.3 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 patients to ensure that they are receiving the correct prescribed treatment.

The format of the personal medication records/medication administration charts had recently been updated to facilitate clear records of prescribing and administration. All current medication administration records were reviewed. They had been fully and accurately maintained.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. There were no controlled drugs which required safe custody prescribed on the day of the inspection. A review of previously prescribed controlled drugs indicated that there were robust arrangements in place for the safe management of controlled drugs.

7.4 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.

We reviewed the management of medicines for three patients who had recently been admitted to Home Treatment House. A copy of the electronic care record was available and staff advised that this was checked against the medicines supplied by each patient on admission. Two nurses were involved in writing and verifying the personal medication records. The medicines had been accurately received into the home and administered in accordance with the most recent directions.

Staff advised that they follow up any discrepancies (between the electronic care record and the medicines supplied) with the patient's GP prior to any administration. A doctor reviews the personal medication records within 72 hours of admission or earlier if there are issues identified.

7.5 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.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. 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.

The record keeping and auditing systems had been reviewed and streamlined recently. 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 audits we completed at the inspection indicated that medicines were being administered as prescribed.

7.6 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 patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported.

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 following any medication related incidents or if a need was identified through the audit process.

8.0 Evaluation of Inspection

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

The outcome of this inspection indicated that robust systems were in place for the safe management of medicines. No areas for improvement with regards to medicines management were identified. We can conclude that patients were being administered their medicines as prescribed by their GP.

We would like to thank the manager and staff for their assitsnce throughout the inspection.

9.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Sharon Casement, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

9.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with 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.

Quality Improvement Plan

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 4 **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that patients' care plans are reviewed in a meaningful and timely manner; the care plans should also evidence collaboration and agreement with patients with regard to the content of the care plan. **Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection**. Ref: 5.0
Area for improvement 2 **Ref**: Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that risk assessments and care plans are current, individualised and reflective of identified needs. Additionally, staff should be adequately trained in developing care plans. **Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection**. Ref: 5.0

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