The Regulation and Quality Improvement Authority

Inspection Report

10 March 2022

Hamilton Care Home

Type of service: Nursing Home
Address: 168 Ballycorr Road, Ballyclare, BT39 9DF
Telephone number: 028 9334 1396

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Registered Provider: Mrs Heather Hamilton **Responsible Individual:** Mrs Heather Hamilton	**Registered Manager:** Miss Linzi Tweedy **Date registered:** Acting manager
Person in charge at the time of inspection: Miss Linzi Tweedy	**Number of registered places:** 36
Categories of care: Nursing Home (NH) I – Old age not falling within any other category	**Number of patients accommodated in the nursing home on the day of this inspection:** 35
Brief description of the accommodation/how the service operates: This is a registered nursing home which provides nursing care for up to 36 patients.	

2.0 Inspection summary

An unannounced inspection took place on 10 March 2022, from 10.10am to 2.45pm. It 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.

Following discussion with the aligned care inspector, it was agreed that all but two of the areas for improvement identified at the last inspection would be followed up at the next care inspection. Two areas for improvement, in relation to fire doors and the application for a change in registered provider, were assessed as met.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records and 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 patients were administered their medicines as prescribed. Two areas for improvement were identified in relation to the denaturing of controlled drugs before disposal and the records for medicines administered in the management of distressed reactions.

Whilst areas for improvement were identified, based on the inspection findings and discussions held, RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the management team, regarding the management of medicines.

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. The inspector also spoke to staff and management about how they plan, deliver and monitor the management of medicines in the home. Patient/representative views were also obtained where possible.

4.0 What people told us about the service?

To reduce footfall throughout the home, the inspector did not meet any patients. Patients were observed to be relaxed and content in the home.

The inspector met with one nurse and the manager. Staff were warm and friendly and it was evident from discussions that they knew the patients well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The nurse spoken with expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and that management were 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 for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes.

At the time of issuing this report, RQIA had received one response from a patient's representative. They expressed that they were very satisfied with the care provided and comments included, "Everything about … provides great reassurance and confidence that my … is receiving excellent care by excellent staff". No staff responses were received.

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 16 August 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 12 (1) **Stated:** First time	The registered person shall ensure the following in regards to the repositioning of patients: • That patients are repositioned in keeping with their prescribed care • That repositioning records are accurately and comprehensively maintained at all times • That the type and/or setting of pressure relieving mattress is effectively managed and documented in the patients care plan.	**Carried forward to the next inspection**
	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.	
Area for improvement 2 **Ref:** Regulation 27 (4) (b) **Stated:** First time	The registered person shall ensure that fire doors are not propped open.	**Met**
	Action taken as confirmed during the inspection: No fire doors were observed to be propped open.	
Area for improvement 3 **Ref:** Regulation 32 (a) **Stated:** First time	The registered person shall ensure that an application is submitted to RQIA in regard to the change in registered provider for Hamilton Care Home.	**Met**
	Action taken as confirmed during the inspection: An application has been submitted to RQIA in regard to the change in registered provider.	

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		Validation of compliance
Area for improvement 1 **Ref:** Standard 35 **Stated:** Second time	The registered person shall ensure that a robust regular system of governance audits shall be completed in accordance with legislative requirements, minimum standards and current best practice. This specifically relates to care record audits and falls audits.	**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.	
Area for improvement 2 **Ref:** Standard 41.7 **Stated:** First time	The registered person shall ensure registered nurses competency and capability assessments are up to date and regularly reviewed.	**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.	
Area for improvement 3 **Ref:** Standard 11 **Stated:** First time	The registered person shall ensure that the provision of activities in the home is reviewed to ensure a contemporaneous record of activities delivered is retained. Activities must be integral part of the care process and care planned for with daily progress notes reflecting activity provision. An activity schedule should also be displayed for patients.	**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.	
Area for improvement 4 **Ref:** Standard 35 **Stated:** First time	The registered person shall ensure wound care audits are completed regularly.	**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?

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 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.

Patients in the home were registered with a GP and medicines were dispensed by a community pharmacist.

Electronic personal medication records were in place for each patient. 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 and hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had verified the personal medication records when they were written and updated to provide a check that they were accurate.

Copies of patients' 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 safe practice.

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 nurses 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 nurses 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.

The management of medicines prescribed on a "when required" basis for distressed reactions was reviewed for four patients. The nurses on duty 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 recorded on personal medication records. Records of administration were maintained and the reason for administration was usually recorded. Care plans directing the use of these medicines for each patient were in place. However, the outcome of their administration was not recorded. An area for improvement was identified.

The management of pain was discussed and was examined for three patients. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans were in place.

Some patients may need their diet modified to ensure that they receive adequate nutrition.

This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

The management of thickening agents was reviewed for four patients. Speech and language assessment reports and care plans were in place. Records of prescribing included the recommended consistency level.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

Care plans were in place when patients required insulin to manage their diabetes.

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 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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

It was agreed that with immediate effect, inhaler spacer devices would be stored bagged on the medicine trolley for infection control purposes and that thickening agents would be moved to another cupboard and stored separately from cleaning agents.

Mostly satisfactory arrangements were in place for the safe disposal of medicines. However, it was evident that although Schedule 2 and 3 controlled drugs were being denatured appropriately prior to disposal, that this was not taking place as required for Schedule 4 (Part1) controlled drugs e.g. diazepam. This had been discussed with staff at the last medicines management inspection. 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 patients to ensure that they are receiving the correct prescribed treatment.

A sample of the electronic medicines administration records was reviewed. Records were found to have been accurately completed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. There were satisfactory arrangements in place for their storage and records (see 5.2.2 regarding disposal).

Management and staff audit medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on most medicines so that they could be easily audited. This is good practice and the manager had already highlighted to staff that this was necessary for every medicine.

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

Review of medicines for patients who had a recent hospital stay and were discharged back to this home, showed that hospital discharge letters had been received and a copy had been forwarded to the patient's GP. The patients' personal medication records had been updated to reflect medication changes which had been initiated during the hospital stay. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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.

The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that these incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence. The type of incidents that should be reported and reporting responsibilities were discussed with the manager.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

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 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 they are supported. Policies and procedures should be up to date and readily available for staff reference.

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. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/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 Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	2*	5*

* The total number of areas for improvement includes five which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Linzi Tweedy, Manager, 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 12 (1) **Stated:** First time **To be completed by:** With immediate effect (16 August 2021)	The registered person shall ensure the following in regards to the repositioning of patients: • That patients are repositioned in keeping with their prescribed care • That repositioning records are accurately and comprehensively maintained at all times • That the type and/or setting of pressure relieving mattress is effectively managed and documented in the patients care plan.
	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: 5.1
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that Schedule 4 (Part 1) controlled drugs are denatured before disposal on every occasion. Ref: 5.2.2
	Response by registered person detailing the actions taken: All Schedule 4 (part 1) controlled drugs are now denatured and disposed of using the returns drug book - this is completed by two registered nurses.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 35 **Stated:** Second time **To be completed by:** 16 September 2021	The registered person shall ensure that a robust regular system of governance audits shall be completed in accordance with legislative requirements, minimum standards and current best practice. This specifically relates to care record audits and falls audits.
	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 41.7 **Stated:** First time **To be completed by:** 30 September 2021	The registered person shall ensure registered nurses competency and capability assessments are up to date and regularly reviewed.
	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 3 **Ref:** Standard 11 **Stated:** First time **To be completed by:** With immediate effect (16 August 2021)	The registered person shall ensure that the provision of activities in the home is reviewed to ensure a contemporaneous record of activities delivered is retained. Activities must be integral part of the care process and care planned for with daily progress notes reflecting activity provision. An activity schedule should also be displayed for patients.
	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 4 **Ref:** Standard 35 **Stated:** First time **To be completed by:** 16 September 2021	The registered person shall ensure wound care audits are completed regularly.
	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 5 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 31 March 2022	The registered person shall ensure that when medicines are administered “when required” for the management of distressed reactions, the reason for and the effect of their use, are recorded on every occasion. Ref: 5.2.1
	Response by registered person detailing the actions taken: All nurses have been advised that all administered PRN medications must be documented on the patients electronic care record with the reason for and the effect of the medication given. This will continue to be monitored.

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