The Regulation and Quality Improvement Authority

Inspection Report

20 August 2024

Hamilton Care Home

Type of service: Nursing Home
Address: 168 Ballycorr Road, Ballyclare, BT39 9DF
Telephone number: 028 93 341396

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: Hamilton Nursing Home Ltd **Registered Person:** Ms Lucinda Dawn Hamilton	**Registered Manager:** Ms Lucinda Dawn Hamilton **Date registered:** 5 June 2008
Person in charge at the time of inspection: Ms Lucinda Hamilton, Manager	**Number of registered places:** 36
Categories of care: Nursing (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: Hamilton Care Home is a nursing home registered to provide nursing care for up to 36 patients. Patient bedrooms are located on the ground floor. Patients have access to communal lounges, dining room and a courtyard.	

2.0 Inspection summary

An unannounced inspection took place on 20 August 2024, from 9.50am to 1.55pm. This was completed by a pharmacist inspector and 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.

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 identified at the last medicines management inspection had been addressed. The two areas for improvement identified at the last care inspection have been carried forward and will be followed up at the next care inspection. No new 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 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. Discussions took place with staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with three nurses, the deputy manager and the manager. 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.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

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.

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 14 March 2024		
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4 **Stated:** Second time	The registered person shall ensure that where a patient has a wound; wound care plans are in place and kept up to date to reflect the actual wound care required.	**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 4 **Stated:** First time	The registered person shall ensure that where a patient has a wound that the wound is redressed as prescribed in the patient's care plan.	**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 18 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: The reason for and the effect of the administration of these medicines was recorded on each occasion. This area for improvement was assessed as met.	

Area for improvement 4 **Ref:** Standard 31 **Stated:** First time	The registered person shall ensure that the destruction/disposal of controlled drugs is completed by and the record signed by the two members of staff involved. As per legislative requirements, professional standards and guidelines.	**Met**
	Action taken as confirmed during the inspection: The record of the destruction/disposal of controlled drugs was completed by and the record signed by the two members of staff involved. This area for improvement was assessed as met.	

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 the community pharmacist.

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 or hospital appointments.

The personal medication records reviewed 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 state that they were accurate. A couple of minor discrepancies were highlighted to nurses and addressed immediately.

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 good practice.

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, diabetes, modified diets etc.

The management of distressed reactions, pain, thickening agents, insulin; and the administration of medicines via the enteral route were reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed at the inspection indicated that prescribed medicines were administered as prescribed.

5.2.2 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 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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

Satisfactory arrangements were in place for the safe disposal of medicines.

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 medicines administration records was reviewed. Records were found to have been fully and accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plans. Care plans were in place when this practice occurred.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on medicines so that they could be easily audited. This is good practice.

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 mostly 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 usually obtained at or prior to admission and details shared with the community pharmacy. Medicine records had been accurately completed. There was evidence that nurses had requested written confirmation of prescribed medicines for one recent admission and it was agreed that this would be followed up immediately.

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.

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.

The audits completed at the inspection indicated that medicines were being administered as prescribed. A couple of minor discrepancies were highlighted for monitoring.

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 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.

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. Policies and procedures were up to date and available for staff reference.

Records of staff training in relation to medicines management and the administration of nutrition and medicines via the enteral route were available for inspection.

6.0 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 Ms Lucinda Hamilton, Registered Manager and Ms Linzi Tweedy, Deputy 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 Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 15 March 2024	The registered person shall ensure that where a patient has a wound; wound care plans are in place and kept up to date to reflect the actual wound care required.
	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 4 **Stated:** First time **To be completed by:** 15 March 2024	The registered person shall ensure that where a patient has a wound that the wound is redressed as prescribed in the patient's care plan.
	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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