# Unannounced Medicines Management Inspection Report
# 8 November 2018

## Haypark

**Type of service: Residential Care Home**
**Address: 36 Whitehall Parade, Belfast, BT7 3GX**
**Tel No: 028 9064 1784**
**Inspector: Frances Gault**

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

## 1.0 What we look for


## 2.0 Profile of service

This is a residential care home that provides care for up to 30 residents as detailed in section 3.0.

## 3.0 Service details

| | |
|---|---|
| **Organisation/Registered Provider:**<br>Haypark Homes Ltd<br><br>**Responsible Individual(s):**<br>Mr J McWhirter | **Registered Manager:**<br>Mrs Jennifer McClean |
| **Person in charge at the time of inspection:**<br><br>Mrs Jennifer McClean | **Date manager registered:**<br><br>01/04/2005 |
| **Categories of care:**<br>I – Old age not falling within any other category.<br>DE – Dementia.<br>MP – Mental disorder excluding learning disability or dementia.<br>MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. | **Number of registered places:**<br>30<br><br>There shall be one identified resident in category RC-MP/MP (E).<br><br>RC-DE for a maximum of five residents only. |

## 4.0 Inspection summary

An unannounced inspection took place on 8 November 2018 from 10.40 to 13.30.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

The inspection assessed progress with any areas for improvement identified since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to medicine records, storage and the management of controlled drugs.

Two areas for improvement were identified in relation to including information about medicines in the care records.

Residents said that they were enjoying the musical activity that was taking place that day.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents' experience.

## 4.1 Inspection outcome

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 0 | 2 |

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Jennifer McClean, Registered 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.

## 4.2 Action/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 8 March 2018. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

## 5.0 How we inspect

Prior to the inspection a range of information relevant to the home was reviewed. This included the following:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

During the inspection the inspector met with several residents in the lounge and dining room and one who was enjoying sitting outside, the registered manager and senior care assistant and the home's community pharmacist.

We provided the registered manager with ten questionnaires to distribute to residents and their representatives, for completion and return to RQIA. 'Have we missed you?' cards were left in the foyer of the home to inform residents/their representatives of how to contact RQIA, to tell us of their experience of the quality of care provided. Flyers providing details of how to raise any concerns were also left in the home. Staff were invited to share their views by completing an online questionnaire.

A poster informing visitors to the home that an inspection was being conducted was displayed.

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

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- care plans
- medicines storage temperatures

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

## 6.0 The inspection

## 6.1 Review of areas for improvement from the most recent inspection dated 8 March 2018

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

This QIP will be validated by the care inspector at the next care inspection.

## 6.2 Review of areas for improvement from the last medicines management inspection dated 30 August 2017

There were no areas for improvement identified as a result of the last medicines management inspection.

## 6.3 Inspection findings

## 6.4 Is care safe?

**Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.**

Medicines were managed by staff who have been trained and deemed competent to do so. The current care staff have all worked in the home for some time. The impact of training was monitored through team meetings, supervision and annual appraisal. The registered manager advised of the training that would be taking place as they were introducing a different monitored dosage system. The community pharmacist who was in the home during the inspection also advised of the support they were planning to give the staff to ensure that the introduction of the new system went as smoothly as possible.

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. Antibiotics and newly prescribed medicines had been received into the home without delay.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records were updated by two members of staff.
The staff were advised that this practice should also be followed when entries on the medicine administration sheets were hand written.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged. One query in relation to the administration was discussed with the manager who agreed to review the record.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. A new medicine refrigerator had just been obtained and the temperature was being monitored. It was agreed that all staff would be shown how to read and reset the thermometer.

**Areas of good practice**

There were examples of good practice in relation to staff training, the management of medicines on admission and controlled drugs.

**Areas for improvement**

No areas for improvement were identified during the inspection.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 0 | 0 |

**6.5 Is care effective?**

**The right care, at the right time in the right place with the best outcome.**

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

The sample of administration records examined indicated that staff documented when medicines prescribed "when required" were administered.
However, there was no record of the reason for the administration of the medicines or of the effect the medicine had had on the resident's condition. An area for improvement was made.

There was little evidence in the care notes as to the reason residents had been prescribed an antibiotic. The details of discussions with the general practitioner and any resultant change to prescribed medicines should be recorded. An area for improvement was made.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. It was acknowledged that staff did maintain fluid charts for these residents, however, there was little evidence in the charts to confirm that the fluids had been thickened, with inconsistencies in the level of recording. This was discussed with the staff on duty and it was agreed that the information on the record would be amended to act as a prompt for completion.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the resident's health were reported to the prescriber.

Areas of good practice were acknowledged. They included the completion of the medicine records which facilitated the audit process.

Practices for the management of medicines were audited throughout the month by the staff and management. It was suggested that staff should also audit the completion of the fluid charts to ensure that these were completed accurately.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to the health needs of the residents.

**Areas of good practice**

There were examples of good practice in relation to the standard of record keeping.

**Areas for improvement**

The reason and outcome of administering "when required" medicines should be recorded.

The details of discussions with the general practitioner and any resultant change to prescribed medicines should be recorded

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 0 | 2 |

**6.6 Is care compassionate?**

**Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.**

The administration of medicines to residents was completed in a caring manner, residents were given time to take their medicines and medicines were administered as discreetly as possible.

During the inspection residents were observed taking part in a musical activity. One gentleman said he was enjoying it even though he couldn't sing. Residents later had their lunch where a choice was offered with most opting for a bowl of stew which smelt delicious. A dessert was also on offer. Those spoken with said that they had enjoyed it. One resident advised that they found the home too warm and this comment was shared with the management.

Throughout the morning staff were heard dealing promptly with requests from residents.

Of the questionnaires that were issued, none were returned from residents, relatives or staff. Any comments from residents, their representatives and staff in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

Residents who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

**Areas of good practice**

Staff listened to residents and relatives and took account of their views.

**Areas for improvement**

No areas for improvement were identified during the inspection.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 0 | 0 |

**6.7 Is the service well led?**

**Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.**

The inspector discussed arrangements in place in relation to the equality of opportunity for service users and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of service users. The manager advised that this was in place.

Written policies and procedures for the management of medicines were in place. These were not examined during the inspection.
A review of the audit records indicated that satisfactory outcomes had been achieved. The registered manager advised that if a discrepancy is identified, this is discussed with staff and learning identified.

Following discussion with the registered manager and care staff, 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.

**Areas of good practice**

There were examples of good practice in relation to governance arrangements. There were clearly defined roles and responsibilities for staff.

**Areas for improvement**

No areas for improvement were identified during the inspection.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 0 | 0 |

## 7.0 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 Mrs Jennifer McClean, Registered 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 residential care 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.

## 7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

## 7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

| Quality Improvement Plan | |
|---|---|
| **Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)** | |
| **Area for improvement 1**<br><br>**Ref**: Standard 8<br><br>**Stated:** First time<br><br>**To be completed by:**<br>8 December 2018 | The registered person shall ensure that, when applicable, the reason and outcome of administering “when required” medicines should be recorded.<br><br>Ref: 6.5<br><br>**Response by registered person detailing the actions taken:**<br>The reason and outcome of administering 'when required' medicines is being correctly recorded in the Resident's MAR sheet |
| **Area for improvement 2**<br><br>**Ref**: Standard 8<br><br>**Stated:** First time<br><br>**To be completed by:**<br>8 December 2018 | The registered person shall ensure that, the details of discussions with the general practitioner and any resultant change to prescribed medicines should be recorded<br><br>Ref: 6.5<br><br>**Response by registered person detailing the actions taken:**<br>The details of discussions with the General Practitioner and any resultant change to prescribed medicines are recorded on the Resident's MAR sheet which is signed by two members of staff and also recorded in the admissions and discharge book. The discharge letter from the Hospital is kept in the Resident's personal file. |

***Please ensure this document is completed in full and returned via the Web Portal***

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