Unannounced Medicines Management Inspection Report
27 April 2018

Hanna Street

Type of service: Residential Care Home
Address: 8 Hanna Street, York Road, Belfast, BT15 1GQ
Tel No: 028 9504 2810
Inspector: Judith Taylor

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 registered residential care home which provides short break care for up to two persons living with learning disability.

3.0 Service details

Organisation/Registered Provider: Belfast HSC Trust **Responsible Individual** Mr Martin Joseph Dillon	**Registered Manager:** Mrs Barbara McGarrity
Person in charge at the time of inspection: Mrs Barbara McGarrity	**Date manager registered:** 1 April 2005
Categories of care: Residential Care (RC): LD – Learning disability LD(E) – Learning disability – over 65 years	**Number of registered places:** 2

4.0 Inspection summary

An unannounced inspection took place on 27 April 2018 from 10.45 to 13.00.

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 during and 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 staff training, the management of medicines at admission and discharge, medicines administration, care planning and the completion of medicine records.

No areas for improvement were identified.

There were no residents accommodated in the home at the time of the inspection.

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	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Barbara McGarrity, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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 24 October 2017. 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

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

During the inspection the inspector met with two members of staff and the registered manager.

A total of 10 questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

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

- medicines received
- personal medication records
- medicine administration records
- medicines transferred
- policies and procedures
- care plans
- training records

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

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 24 October 2017

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 1 February 2017

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 30 **Stated:** First time	The registered provider should review the admission process to ensure that records clearly detail which medicines are prescribed for the period of respite care.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that this had been reviewed. Personal medication records had been rewritten in consultation with the residents' families and prescribers. She confirmed that staff contacted the family if any medicine was listed and had not been received. A sample of records was reviewed and no further concerns were identified.	

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 impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in

medicines management, epilepsy awareness, diabetes awareness and the administration of emergency medicines was provided every two to three years. A sample of training records was provided.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and discharge from the home. Staff provided details of the processes to ensure that up to date medicines information was obtained at or prior to the period of care, including the management of any medicine changes since the last admission. This included telephoned and written confirmation of each resident's medicine regime as necessary. Staff advised that the resident's general practitioner would sign the personal medication records.

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

Any medicines remaining at the end of the period of care were returned to the resident's family/carers.

There were no medicines held in stock at the time of the inspection. When held in stock, medicines were held in a lockable medicine trolley. Satisfactory arrangements were in place for the management of medicine keys.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment and the management of medicines on admission and discharge.

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.

As there were no medicines held in stock, audit trails were completed using a sample of medicine records for residents who had recently been accommodated in the home. The outcomes of the audit trails showed that largely satisfactory outcomes had been achieved, indicating that the medicines had been administered as prescribed. However, a few discrepancies were identified and highlighted to the registered manager. She gave assurances that this would be raised with staff as soon as possible.

Epilepsy management plans were located in the care files and medicine folders.

Appropriate arrangements were in place for administering medicines in food/fluids to aid swallowing. This was clearly detailed in resident's records.

The management of pain was discussed. Staff advised that analgesia was rarely required and was discussed with the resident's family/carer as part of the admission process. Staff advised that they were aware of how each resident would express pain. Details were recorded in the resident's care files.

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 family/carer.

With the exception of the small number of records as discussed above, the medicine records were well maintained and facilitated the audit process.

Practices for the management of medicines were audited at the end of each period of care.

Following discussion with the registered manager and staff and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to the resident's needs.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines. Staff were knowledgeable about the resident's medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

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 procedures for the administration of medicines were discussed. Staff advised that this was usually undertaken by two members of staff and medicines were administered in a quiet and calm environment and in accordance with the resident's preferences. Staff confirmed that each resident was encouraged to the take their medicines and were given plenty of time to take them.

We were informed about the good working relationships with the residents, their relatives and staff; and also of the procedures in place to ensure that each resident felt safe and comfortable during their period of care. Many of the staff had worked in the home for several years and those spoken to advised they were very familiar with each resident's likes and dislikes.

Of the questionnaires that were issued, none were returned from residents and their representatives with the specified time frame (two weeks). Any comments from residents and

their representatives in returned questionnaires received after the return date will be shared with the registered manager for their information and action as required.

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 residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents. The registered manager advised that there were arrangements in place to implement the collection of equality data within Hanna Street.

Written policies and procedures for the management of medicines were in place. These were readily available for staff reference. The registered manager also provided details of the review of the home's safeguarding policy.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents and advised of the systems in place to ensure that all staff were informed, to prevent recurrence. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

The auditing process for medicines management was discussed. We were advised that audits were completed by management and outcomes were shared with staff as necessary.

Following discussion with the staff, it was evident that they 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 through team meetings and supervision. Staff advised that they felt well supported in their work and that there were good working relationships in the home.

No questionnaires were completed by staff within the specified time frame (two weeks).

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. 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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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