The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report
1 February 2017

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

1.0 Summary

An unannounced inspection of Hanna Street took place on 1 February 2017 from 10.40 to 12.40.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for residents. Staff administering medicines were trained and competent. There were largely satisfactory systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. One area for improvement in relation to the admission process at each period of respite care was identified and a recommendation was made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure that residents were receiving their medicines as prescribed. Specific areas of medicines management were detailed in care plans. No requirements or recommendations were made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Whilst there were no residents present in the home on the day of the inspection, it was evident from discussion with staff and a review of care files pertaining to medicines, the residents' needs were clearly detailed and staff were knowledgeable regarding the residents' needs, likes and dislikes. No requirements or recommendations were made.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. No requirements or recommendations were made.

This inspection was underpinned by 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).

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Barbara McGarrity, 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.

1.2 Actions/enforcement taken following the most recent care inspection

There were no further actions required to be taken following the most recent inspection on 11 October 2016.

2.0 Service details

Registered organisation/registered person: Belfast HSC Trust/Mr Martin Joseph Dillon	**Registered manager:** Mrs Barbara McGarrity
Person in charge of the home at the time of inspection: Mrs Barbara McGarrity	**Date manager registered:** 1 April 2005
Categories of care: RC-LD, RC-LD(E)	**Number of registered places:** 2

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection.

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

Nineteen questionnaires were issued to residents, relatives/residents' representatives and staff, with a request that these were completed and returned within one week of the inspection.

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

- medicines received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- medicine audits
- policies and procedures
- care plans
- training records

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 11 October 2016

The most recent inspection of the home was an unannounced care inspection. No requirements or recommendations were made.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 4 October 2013

There were no requirements or recommendations made as a result of the last medicines management inspection.

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. The impact of training was monitored through team meetings, quarterly supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management and other areas of healthcare was provided for designated staff every two years. This included training in diabetes awareness, the management of epilepsy and the administration of emergency medicines.

There were largely satisfactory procedures in place to ensure the safe management of medicines during a resident's admission to the home for each period of respite care and their discharge from the home. Personal medication records were signed by the prescriber. Medicines were labelled appropriately. However, from the sample of records examined it was found that some prescribed medicines were not received at the time of the respite care. Some of these were prescribed on a 'when required' basis. There was no evidence that this had been identified or followed up with the relevant persons. The registered manager advised that staff would usually contact the relative. The need for records of these activities was highlighted. A recommendation was made.

Discontinued or expired medicines were returned to the residents' relative/representative.

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 suitable arrangements in place for medicines which required refrigeration.

Areas for improvement

The systems for checking medicines at the beginning of each period of respite care should be reviewed. A recommendation was made.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

The sample of medicines examined had been administered in accordance with the prescriber's instructions.

A care plan detailing the management of epileptic seizures was in place.

The management of pain was reviewed. The registered manager confirmed that this would be discussed with the family as needed. A small number of resident's records were examined. Medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. Staff advised that most of the residents could tell staff if they were in pain. They further advised that they had worked in the home for several years and that residents were accommodated for respite care on a regular basis. They stated they were very familiar with each resident and how they would express pain. Pain management was included in the residents' care and support plan.

Appropriate arrangements were in place for administering medicines in food to aid swallowing. A care plan was maintained.

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 and the prescriber.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to issues or concerns regarding residents' healthcare needs.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

One resident was accommodated for a period of respite care; however, this resident was attending the day centre at the time of the inspection. Therefore the administration of medicines to the resident was not observed and it was not possible to ascertain the views and opinions of the resident.

Following discussion with staff it was ascertained that medicines were administered in accordance with the residents' likes and dislikes and as specified in their care plan.

As part of the inspection process, questionnaires were issued to residents, relatives/residents' representatives and staff. Three staff completed and returned questionnaires. The responses were recorded as 'very satisfied' with the management of medicines in the home.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. These had been reviewed in January 2017. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There was evidence that medicines management was a focus in the staff meetings. The registered manager provided a sample of areas which were to be included in the staff meeting scheduled for next week.

There were robust arrangements in place for the management of medicine related incidents. Staff were aware of how to identify and report incidents. Systems were in place to ensure that all staff were informed of incidents and the learning implemented.

A satisfactory auditing system for medicines management was in place. All medicines were audited at the end of each period of respite care. Any areas for improvement were discussed at staff meetings and at each handover.

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 commented on the good relationships within the home, the support provided within the staff team and by the registered manager. They spoke positively about their work.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Barbara McGarrity, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to the **RQIA web portal** for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 3 March 2017	The registered provider should review the admission process to ensure that records clearly detail which medicines are prescribed for the period of respite care.
	Response by registered provider detailing the actions taken: In response to this recommendation the admission process for the shortbreaks service has been reviewed. Staff have been reminded that it is their responsiblity to thoroughly check that all medicines, including "when required" medications, are received. If there are any discrepancies relatives will be contacted and be asked to rectify. Records of the contact and outcome will be held in the residents file.

Please ensure this document is completed in full and returned to the RQIA web portal

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