The Regulation and Quality Improvement Authority

Review of The Management of Medicines During a Service User's Admission To a Care Home

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Assurance, Challenge and Improvement in Health and Social Care

Introduction

When service users are admitted to care homes it is important that staff have accurate information about their medicines. One of the standards within the Department of Health's Medicines Optimisation Quality Framework requires that:

"Checks occur at each transition of care to ensure that the transfer of medicines and medicines information between patients, carers and health and social care workers is safe accurate and timely."

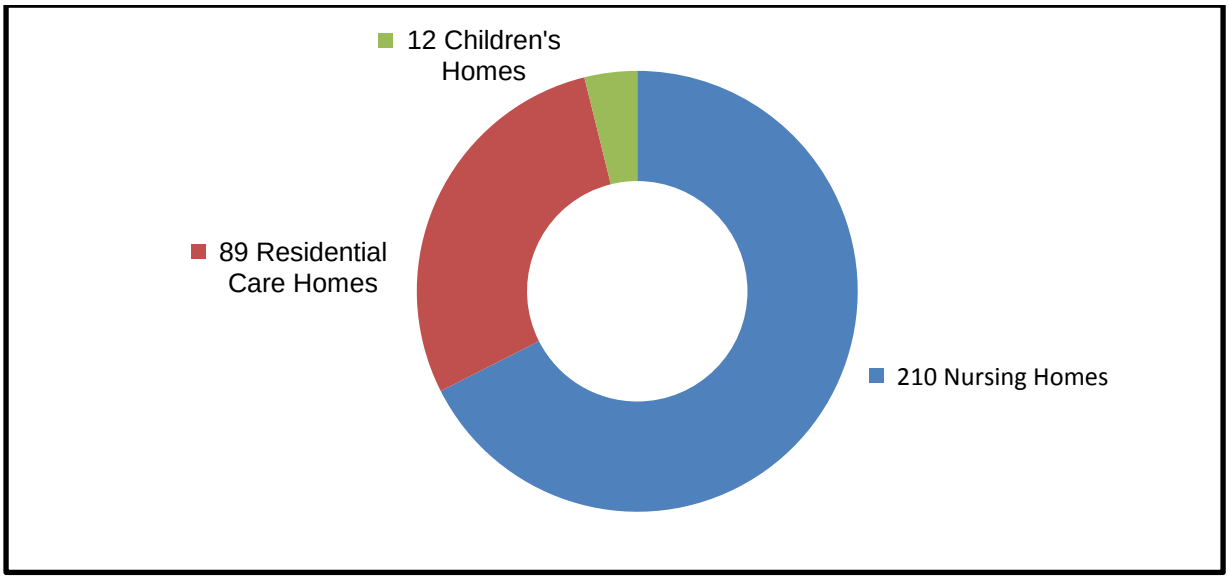
As part of the business objectives in 2017-18, the pharmacist inspectors reviewed the arrangements in place for medicines during the admission of service users to care homes. During our medicines management inspections we collated the information when we reviewed the admission arrangements.

We wanted to find out if safe systems were in place for medicines when service users were admitted to homes. We wanted to make sure that all the relevant information was obtained and communicated to the staff and healthcare professionals as necessary, with the outcome that the service user's medicines were available for administration and administered as prescribed.

What we did

Throughout the inspection year, 1 April 2017 to 31 March 2018, pharmacist inspectors reviewed the admission process in the homes we inspected. Table 1 shows the number of inspections we did where there had been a recent admission.

Table 1: Total number of homes assessed



We looked to see if:

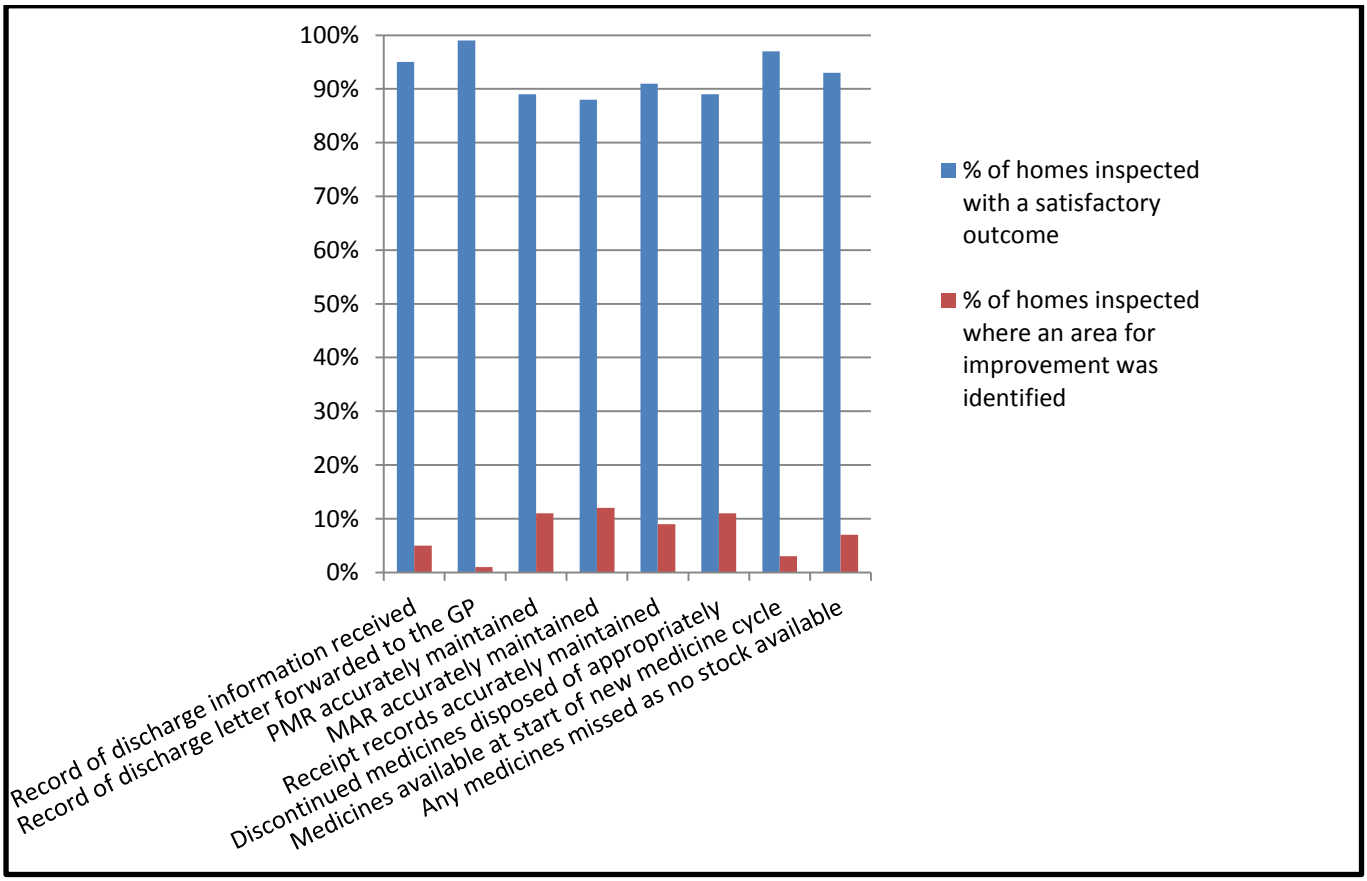
- satisfactory discharge information had been obtained either from the hospital, the service user's General Practitioner (GP) if the service user was admitted from home or from another care home if they had transferred from another setting
- a copy of the hospital discharge information was forwarded to the service user's GP
- the personal medication record (PMR) written by staff in the home had the correct details and had been checked and signed by two staff
- the medication administration records (MAR) were accurately written and signed by two staff
- there was an accurate receipt of all incoming medicines
- any medicines received into the home which were no longer required, were removed from stock and disposed of
- there were good stock control systems in place to ensure the service users' medicines were available for administration.

What we found

The findings, as detailed in Table 2, show that in the majority of homes i.e. over 88 per cent, there were safe systems in place for the management of service users' medicines at the time of admission or readmission to the home. This indicates that these systems were well embedded into routine practice.

In almost all of the homes inspected, staff had forwarded a copy of the hospital discharge information to the service user's GP and had obtained written confirmation of medicine regimes at or prior to admission to the care home. However, there were a few occasions when the medicine was not available for administration. At the inspection, staff provided assurances that this was being addressed with the prescriber, hospital and/or community pharmacy.

Table 2: Percentage of care homes with robust systems in place for the admission of service users



Areas of good practice identified during inspections

- Written information was received in relation to medicines when service users were admitted to the home
- the hospital discharge information was forwarded to the service user's GP
- there were good stock control systems in place to ensure that medicines were available for administration on admission and thereafter
- there was an accurate receipt of all incoming medicines.

Areas for improvement identified during inspections

- Personal medication records and medicine administration records should be up to date and accurate
- any transcribing should involve two staff to verify and ensure accuracy, with both staff signing the records
- medicines received into the home which are no longer required, should be removed from stock and disposed of.

Conclusion

There were robust arrangements in place when service users were admitted to care homes to confirm the dosage of medicines that they are currently prescribed.

As part of the internal systems in RQIA, the pharmacist team routinely share any concerns in relation to transfers from hospital settings with the hospital inspection team within RQIA and the lead pharmacist in the relevant trust.

Appendix

Care Standards for Nursing Homes, April 2015 (DHSSPSNI)

The Nursing Homes Regulations (Northern Ireland) 2005

Residential Care Home Minimum Standards, updated August 2011 (DHSSPSNI)

The Residential Care Homes Regulations (Northern Ireland) 2005

The Children's Homes Regulations (Northern Ireland) 2005

Children_Homes_Standards - April 2014

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