Inspection Report
22 October 2020

Kilwee Care Home

Type of Home: Nursing Home
Address: 42f Cloona Park, Dunmurry, Belfast BT17 0HH
Tel No: 028 9061 8703
Inspector: Helen Daly

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 this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a nursing home which is registered to provide care for up to 32 patients.

2.0 Service details

Organisation/Registered Provider: Merit Retail Ltd **Responsible Individual:** Mr Jarlath Conway	**Registered Manager and date registered:** Ms Deborah Campbell, Acting no application required
Person in charge at the time of inspection: Ms Deborah Campbell	**Number of registered places:** 32 This number includes a maximum of 20 patients in category NH-DE and 12 patients in categories NH-I, NH-PH and NH-PH(E).
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years MP- mental disorder excluding learning disability or dementia DE – dementia	**Total number of patients in the nursing home on the day of this inspection:** 29

3.0 Inspection focus

This inspection was undertaken by a pharmacist inspector on 22 October 2020 from 10.15 to 15.00.

This inspection focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified since the last care and medicines management inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to patients
- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drug records
- care plans related to medicines management
- governance and audit in relation to medicines management
- staff training and competency records
- medicine storage temperatures
- RQIA registration certificate

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	2*	3*

*The total number of areas for improvement includes three which have been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Deborah Campbell, 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.

5.0 What has the home done to meet any areas for improvement identified at the last medicines management inspection (18 July 2019) and care inspection (5 August 2020)?

The area for improvement identified at the last medicines management inspection was validated during the care inspection on 19 November 2019.

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection (5 August 2020)</th></tr>
<tr><th colspan="2">Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td>Area for improvement 1

Ref: Regulation 13 (1) (a) (b)

Stated: First time</td><td>The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals.

This is in specific reference to care plans and daily recording charts:

• accurately reflect the frequency of repositioning
• contain clear information regarding the recommended type of pressure relieving mattress
• contain clear information regarding patients’ recommended daily fluid intake and action to take if it is below the set target
• accurately reflect the level of assistance required with personal care
• accurately reflect the patients pain management
• contain clear information regarding medical conditions where treatment is being provided
• where a patient has a history of weight loss the MUST is accurately reflected within the care records.</td><td rowspan="2">Carried forward for review at the next inspection</td></tr>
<tr><td colspan="2">Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.</td></tr>
</table>

Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the environmental and infection prevention and control issues identified during this inspection are urgently addressed and a system is initiated to monitor ongoing compliance. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.**	**Carried forward for review at the next inspection**
Area for improvement 3 **Ref:** Regulation 27 (2) (t) **Stated:** First time	The registered person shall, having regard to the number and needs of the patients, ensure that a risk assessment to manage health and safety is carried out and updated when necessary. With specific reference to safe storage of: • razors • denture cleaning tablets • food and food thickening agents • medicines prescribed for topical application **Action taken as confirmed during the inspection**: Observation of the environment and a review of governance records provided evidence that this area for improvement has been met The risk assessments were available for inspection. Razors and denture cleaning tablets were observed to be stored in locked cabinets in each patient's ensuite bathroom. Food and food thickening agents were stored in locked cupboards and a locked fridge in the kitchenette. Medicines prescribed for topical application were stored in the medicines trolleys.	**Met**

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		Validation of compliance
Area for improvement 1 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure that the daily menu is displayed in a suitable format and in an appropriate location, detailing what is available at each mealtime.	**Met**
	Action taken as confirmed during the inspection: The daily menu was available in written and pictorial format in the dining room/kitchenette. It was up to date and accurately reflected the meals served.	
Area for improvement 2 **Ref:** Standard 44.5 **Stated:** First time	The registered person shall ensure security measures are operated that restrict unauthorised access to the home to protect patients and their valuables, the premises and their contents. With specific reference to the use of an identified fire exit door.	**Met**
	Action taken as confirmed during the inspection: The manager advised that this had been discussed with all staff and was monitored regularly. The identified door was observed to be locked during the inspection.	
Area for improvement 3 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home: • hand hygiene and PPE compliance audits should be sufficiently robust to ensure that any IPC deficits are appropriately identified and actioned • governance audits in respect of care records to ensure care plans and care records are maintained as required	**Carried forward for review at the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.	

6.0 What people told us about this home?

Patients were observed to be relaxing in their bedrooms, in the lounge or in the kitchenette during the inspection.

We greeted several patients and spoke with one patient. The patient said they "could not be happier and the staff are great".

Staff were warm and friendly and it was evident from their interactions that they knew the patients well.

We met with one care assistant, two registered nurses and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed throughout the home.

Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after patients and meet their needs.

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.

7.0 Inspection Findings

7.1 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 will change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Patients in the home were registered with a local 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 e.g. medication reviews, hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had checked and signed the personal medication records when they were written and updated to check that they were accurate.

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, modified diets, self-administration etc.

Patients may sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions for six patients. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available in the medicines file. However, when more than one medicine was prescribed the personal medication records and care plans did not provide details of which medicine should be used first and the timing interval before a second medicine can be administered. Records of administration were clearly recorded. However, the reason for and outcome of administration was recorded for some patients only. An area for improvement was identified.

We reviewed the management of pain for three patients and found that the care plan and daily recording charts were in accordance with the patients' planned care and the recommendations of other health care professionals. The care plans and personal medication records provided clear details. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Pain was assessed at each medicine round. This is good practice.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

We reviewed the management of thickening agents for three patients. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral tube. We reviewed the management of medicines and nutrition via the enteral route for one patient. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

7.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines 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 areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located.

Medicines were observed to be stored at the manufacturers' recommended temperatures and controlled drugs were stored in controlled drugs cabinets.

We reviewed the disposal arrangements for medicines. Discontinued medicines were returned to the community pharmacy for disposal and records maintained.

7.3 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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records. The sample of these records reviewed was found to have been fully and accurately completed. The records were filed once completed and they were readily retrievable for review/audit.

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 was recorded in controlled drug record books. Balances were checked at each handover of responsibility.

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

The audits completed during this inspection showed that medicines had been given as prescribed.

A small number of patients have their medicines administered in food/drinks to assist administration. This practice had been authorised by the patient's GP. However, for one patient a care plan was not in place and for a second patient the care plan contained limited details.

The care plan should contain details on how the patient likes to take their medicines and the need for close supervision to ensure that all of the medicine dose has been administered. An area for improvement was identified.

7.4 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.

We reviewed the management of medicines for new patients or patients returning to the home from a hospital admission. Written confirmation of the medicine regime had been obtained and a copy of any hospital discharge letter had been forwarded to the patient's GP. Personal medication records had been verified and signed by two nurses. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

7.5 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.

The audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported.

7.6 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 staff are competent in managing medicines and that staff are supported.

Staff in the home had received a structured induction which included medicines management when this forms part of their role.

Update training on medicines management was planned for November 2020. The manager advised that competencies would be re-assessed following this training.

Records of staff training and competency assessments were available for inspection.

8.0 Evaluation of Inspection

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

Whilst we identified areas for improvement in relation to care planning for distressed reactions and adding medicines to food/drinks to assist swallowing, we can conclude that overall medicines were being administered as prescribed by the patients' GPs.

We would like to thank the patients and staff for their assistance throughout the inspection.

9.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Deborah Campbell, 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 nursing 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.

9.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

9.2 Actions to be taken by the home

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 Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals. This is in specific reference to care plans and daily recording charts: • accurately reflect the frequency of repositioning • contain clear information regarding the recommended type of pressure relieving mattress • contain clear information regarding patients' recommended daily fluid intake and action to take if it is below the set target • accurately reflect the level of assistance required with personal care • accurately reflect the patients pain management • contain clear information regarding medical conditions where treatment is being provided • where a patient has a history of weight loss the MUST is accurately reflected within the care records.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next inspection. Ref: 5.0
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the environmental and infection prevention and control issues identified during this inspection are urgently addressed and a system is initiated to monitor ongoing compliance.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next inspection. Ref: 5.0

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 5 September 2020	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. • hand hygiene and PPE compliance audits should be sufficiently robust to ensure that any IPC deficits are appropriately identified and actioned • governance audits in respect of care records to ensure care plans and care records are maintained as required.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next inspection. Ref: 5.0
Area for improvement 2 **Ref**: Standard 18 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall review and revise the management of distressed reactions to ensure that: • when more than one medicine is prescribed the personal medication records and care plans provide details of which medicine should be used first line and the timing interval before a second medicine can be administered • the reason for and outcome of administration are recorded. Ref: 7.1
	Response by registered person detailing the actions taken: Staff ensure that clear directions are given from prescribers and that this information is recorded on care plans and medicines kardex. A form has been initiated whereby staff record reason for administration and effectiveness of same. To ensure compliance with this, the manager observes this as part of her monthly audits.
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that care plans for adding medicines to food/drink to assist administration contain sufficient detail to direct the required care. Ref: 7.3
	Response by registered person detailing the actions taken: Staff are to ensure that care plans reflect the residents choice/preference of foods/fluids that assist with the administration of medications. As the residents have the choice of foods daily and this might change, staff are to record administration choices in daily progress notes. Staff have received supervision to ensure that this is adhered to.

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

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