Inspection Report

26 September 2023

Kilwee Care Home

Type of service: Nursing Home
Address: 42f Cloona Park, Dunmurry, Belfast, BT17 0HH
Telephone number: 028 9061 8703

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Merit Retail Limited **Responsible Individual:** Mr Jarlath Conway	**Registered Manager:** Ms Deborah Campbell **Date registered:** 3 June 2021
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 DE – dementia MP – mental disorder excluding learning disability or dementia PH(E) - physical disability other than sensory impairment – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 31
Brief description of the accommodation/how the service operates: Kilwee Care Home is a registered nursing home which provides nursing care for up to 32 patients. The home is divided into two units over two floors. The ground floor unit provides care for patients with nursing needs within old age, mental health, and physical disability categories. The first floor unit provides care to patients with nursing dementia needs. This nursing home shares the same building as a residential care home which occupies the second floor of the building. The registered manager for Kilwee Care Home manages both the nursing home and the residential care home.	

2.0 Inspection summary

An unannounced inspection took place on 26 September 2023, from 10.00am to 2.40pm. This was completed by a pharmacist inspector. The inspection focused on medicines management within the home. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

The areas for improvement identified at the last care inspection have been carried forward and will be followed up at the next care inspection.

Review of medicines management found that mostly satisfactory arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were largely well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered the majority of their medicines as prescribed. Two new areas for improvement were identified in relation to monitoring and recording the temperature of the medicines refrigerator and ensuring that inhaled medicines are administered as prescribed and accurate records maintained.

Whilst areas for improvement were identified, it was concluded that overall, with the exception of a small number of medicines, the patients were being administered their medicines as prescribed.

RQIA would like to thank the staff for their assistance throughout the inspection.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection, information held by RQIA about this home was reviewed. This included previous inspection findings, incidents and correspondence. The inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke with staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with nursing staff and the manager. Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

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.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

Areas for improvement from the last inspection on 7 August 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 20 (1) (c) (ii) **Stated:** First time	The registered persons shall ensure that there is a robust system in place for monitoring staffs' registration status with NISCC. The system should clearly state staffs' start dates and appropriate action should be taken if staff are found to be working unregistered. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**
Action required to ensure compliance with Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 37 **Stated:** First time	The registered persons shall ensure that governance records pertaining to Kilwee nursing home are maintained separately from those records pertaining to Kilwee residential home. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**

5.2 Inspection findings

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

Patients in the home were registered with a 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, for example, at medication reviews or hospital appointments.

The personal medication records reviewed at the inspection were mostly accurate and up to date. A small number of minor discrepancies were highlighted to the manager for close monitoring. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to state 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.

Patients will 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, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines prescribed on a "when required" basis distressed reactions was reviewed for four patients. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. Records included the reason for and outcome for the majority of administrations.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans and pain assessments were in place and reviewed regularly.

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.

The management of thickening agents was reviewed for three patients. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

5.2.2 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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the current, maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. Review of records showed that the temperatures recorded were regularly outside the recommended range and no action had been taken by staff. An area for improvement was identified.

Satisfactory arrangements were in place for the safe disposal of medicines.

5.2.3 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.

A sample of the medicines administration records was reviewed. The majority of records were found to have been accurately completed. Audits completed during the inspection on inhaled medicines for several residents indicated that administration records were not accurate and that these medicines had not been administered as prescribed. This had not been identified via the home's own audit process. Prescribed medicines must be administered as prescribed and accurate records maintained, including reasons for any omissions. The administration of these medicines should be monitored closely via the home's audit system and compliance issues should be discussed with the patient reported to the prescriber as necessary. An area for improvement was identified.

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 should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plans. Written consent and care plans were in place when this practice occurred.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice. As detailed above, the audit process should include inhaled medicines.

5.2.4 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.

There had been no recent admissions to the home. However, the admission process for patients new to the home or returning to the home after receiving hospital care was reviewed. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the patient's medicines and this was shared with the community pharmacist.

5.2.5 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. A robust audit system will help staff to identify medicine related incidents and is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff.

One medicine related incident had been reported to RQIA since the last inspection and was discussed with the manager. There was evidence that the incident had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence. However, some medicine incidents may not have been identified (see section 5.2.3). The manager gave an assurance that this would be monitored through audit. Advice was given and the RQIA guidance on the notification of medication related incidents was shared. The manager agreed to share with all staff to ensure they are aware of what must be reported to RQIA.

5.2.6 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 they staff are competent in managing medicines and that they are supported.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal.

The manager gave an assurance that all staff would be given refresher training on monitoring and recording the temperatures of the medicine refrigerator to ensure appropriate action is taken when the temperature is outside the recommended range (see section 5.2.2).

6.0 Quality Improvement Plan/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 or the Care Standards for Nursing Homes, 2022.

	Regulations	Standards
Total number of Areas for Improvement	2*	2*

* The total number of areas for improvement includes two which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Deborah Campbell, Registered Manager, and Mrs Victoria Humphries, Regional Operations Manager (via telephone) as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 20 (1) (c) (ii) **Stated:** First time **To be completed by:** With immediate effect (7 August 2023)	The registered persons shall ensure that there is a robust system in place for monitoring staffs' registration status with NISCC. The system should clearly state staffs' start dates and appropriate action should be taken if staff are found to be working unregistered.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** With immediate effect (26 September 2023)	The registered person shall ensure that medicines are administered as prescribed and accurate records maintained, including reasons for any omissions. This area for improvement is made regarding inhaler preparations. Ref: 5.2.3 & 5.2.5
	Response by registered person detailing the actions taken: The audit process now includes an inhaler audit. This will indicate amount given and reason for omission. This will be monitored closely during the homes audit system.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 37 **Stated:** First time **To be completed by:** 8 September 2023	The registered persons shall ensure that governance records pertaining to Kilwee nursing home are maintained separately from those records pertaining to Kilwee residential home.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1

Area for improvement 2 **Ref:** Standard 30 **Stated:** First time **To be completed by:** With immediate effect (26 September 2023)	The registered person shall ensure that the maximum, minimum and current temperatures of the medicine refrigerator are monitored and recorded daily and appropriate action is taken when the temperature recorded is outside the recommended range of 2-8ºC. Ref: 5.2.2 & 5.2.6
	Response by registered person detailing the actions taken: Staff have been advised through supervision that the cold storage temperature must be between 2 - 8 degrees and where there is a variation in this temperature, the fridge must be reset and another temperature reading to be sought. If the temperature continues to be outside these limits then this must be reported to the pharmacist as soon as possible and actioned immediately..

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

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care