The Regulation and Quality Improvement Authority

Inspection Report

13 & 21 June 2022

Weavers House Nursing Home

Type of service: Nursing Home
Address: 40 Moneymore Road, Cookstown, Tyrone, BT80 8EH
Telephone number: 028 8676 7684

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: Kathyrn Homes Ltd **Responsible Individual** Mr Stuart Johnstone	**Registered Manager:** Miss Andrea Harkness **Date registered:** 12 June 2020
Person in charge at the time of inspection: Miss Andrea Harkness	**Number of registered places:** 18 A maximum of eighteen patients in category NH-DE.
Categories of care: Nursing Home (NH) DE – dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 17
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 18 persons. The home is situated on the ground floor of the building with a residential care home occupying the first and second floors.	

2.0 Inspection summary

An unannounced medicines management and finance inspection took place on 13 June 2022 from 10:40am to 2:15pm and on 21 June 2022 from 11:15am 1:00pm. The inspection was completed by a pharmacist inspector and finance inspector and focused on medicines management and finance within the home. The purpose of the inspection was to assess if the home was delivering safe, effective, compassionate care and if the home was well led in relation to medicines management and the management of patients' finances.

The inspection also assessed progress with five areas for improvement identified at the last inspection. Following discussion with the aligned care inspector, it was agreed that two areas for improvement identified at the last care inspection would be followed up at the next care inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed.

The outcome of this inspection concluded that the areas for improvement regarding patients' finances, identified at the last inspection had been addressed. No new areas for improvement were identified.

Based on the inspection findings and discussions held, RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the management team with respect to medicines management and finance.

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. A sample of patients' financial files and records were also reviewed. Staff views were also obtained.

4.0 What people told us about the service

The inspectors met with nursing staff and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

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

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.

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 20 July 2021		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 14.12 **Stated:** First time	The registered person shall ensure a reconciliation of patients' personal monies, the comfort fund and any related bank accounts are carried out and signed and dated by two people at least quarterly.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of records confirmed that reconciliations of monies managed on behalf of patients, (including comfort fund and monies retained in the patients' bank account) were undertaken on a monthly basis. The records of the reconciliations were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.	
Area for improvement 2 **Ref:** Standard 14.6 **Stated:** Second time	The registered person shall ensure that each patient is provided with personal monies authorisation for signature detailing the authority the home had been provided with to spend each individual patient's money on identified goods and services.	**Met**
	Action taken as confirmed during the inspection: A review of two patients' files evidenced that written authorisation forms were in place for the patients. The forms detailed the items members of staff were authorised to purchase from the patients' monies. The forms were signed by the patients or their representatives.	

Area for improvement 3 **Ref:** Standard 2.8 **Stated:** Second time	The registered person shall ensure that patients or their representatives are advised of the up to date fee arrangements which constitute a change to each patients' individual written agreement with the home. Individual written agreements should be kept up to date with any change to the patient's agreement agreed in writing by the patient or their representative.	**Met**
	Action taken as confirmed during the inspection: A review of two patients' files evidenced that written agreements showing the current weekly fee were retained in both files. The agreements were signed by the patients, or their representatives and a representative from the home.	
Area for improvement 4 **Ref:** Standard 14.10 **Stated:** First time	The registered person shall ensure that at least two signatures are recorded against the transactions from the patients' comfort fund.	**Met**
	Action taken as confirmed during the inspection: A review of a sample of transactions from the patients' comfort fund confirmed that this area for improvement had been met.	
Area for improvement 5 **Ref:** Standard 14.9 **Stated:** First time	The registered person shall contact the Health and Social Care Trust to ensure that the items held in the safe place are forwarded to the patient identified during the inspection.	**Met**
	Action taken as confirmed during the inspection: Discussion with the manager and a review of records confirmed that the items belonging to the patient had been forwarded to the patient's care manager at the Health and Social Care Trust.	
Area for improvement 6 **Ref:** Standard 4 **Stated:** First time	The registered persons shall ensure that the care plans accurately reflect the needs of the patients in relation to bowel management.	**Carried forward to the next inspection**
	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.	

Area for improvement 7 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that the daily evaluations of care a patient centred, meaningful and reflective of the care provided. **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 accurate and up to date. 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. A small number of obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the patient. This was rectified by the manager on the day of the inspection and assurances were provided that obsolete records would be suitably archived moving forward.

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 nurses 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 nurses 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 for the management of distressed reactions was reviewed for three patients. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Nurses knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. The majority of records included the reason for and outcome of each administration. Nurses were reminded to consistently record the reason and outcome for all administrations.

The management of pain was discussed. Nurses 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 two 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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

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. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. The records were filed once completed and were readily retrievable for review.

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 were recorded in the controlled drug record book. Review of controlled drug patch application charts identified these records were not consistent with the records in the controlled drug record book and the medicine administration records. The manager gave an assurance that the patch application charts would be reviewed following the inspection and this would be included in nurse supervisions to ensure the records are completed accurately.

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 including running stock balances of all boxed medicines. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

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 discussed. 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.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

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. Policies and procedures should be up to date and readily available for staff reference.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments. Records of annual training completed by nurses responsible for medicines management were in place and available for review.

7.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	2*

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

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

Quality Improvement Plan

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Immediately and ongoing (18 August 2020)	The registered persons shall ensure that the care plans accurately reflect the needs of the patients in relation to bowel management. **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 4 **Stated:** First time **To be completed by:** Immediately and ongoing (18 August 2020)	The registered person shall ensure that the daily evaluations of care a patient centred, meaningful and reflective of the care provided. **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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

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

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