The Regulation and Quality Improvement Authority

Inspection Report

24 & 25 January 2023

Fruithill

Type of service: Nursing Home
Address: 20 Fruithill Park, Andersonstown, Belfast, BT11 8GD
Telephone number: 028 9061 7717

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: Brooklawn Ltd **Responsible Individual:** Mr Paul McGranaghan	**Registered Manager:** Mr Seon MacStiofain **Date registered:** 29 January 2020
Person in charge at the time of inspection: Ms Ema Braga, Deputy Manager, 10.15am – 11.00am Mr Seon MacStiofain, from 11.00 am onwards	**Number of registered places:** 36 There shall be a maximum of two patients accommodated in category NH-LD. The home is approved to provide care on a day basis only to two persons.
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 TI – terminally ill LD – learning disability	**Number of patients accommodated in the nursing home on the day of this inspection:** 34
Brief description of the accommodation/how the service operates: Fruithill is a registered nursing home which provides nursing care for up to 36 patients. Accommodation is provided over two floors.	

2.0 Inspection summary

This inspection took place on 24 and 25 January 2023. On 24 January the inspection was unannounced and took place from 10.15am to 4.50pm, focussing on medicines management. It was completed by a pharmacist inspector. The remainder of the inspection, on 25 January, was announced and took place from 10.20am to 1.00pm. It focused on the management of patients' finances and property within the home and was completed by a finance inspector.

The purpose of the inspection was to determine if the improvements in relation to medicines management noted at the last inspection had been sustained, and to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management and the management of patients' finances and property.

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

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan (QIP) and include: maintaining accurate records of medicines received, administration of medicines as prescribed and accurate/contemporaneous recording, robust audit and governance of medicines management, and staff training and competency assessment.

Despite the identified deficits in medicines management, the majority of medicines were administered as prescribed. The findings of this report will aid staff to make the necessary improvements to ensure safe systems are in place for medicines management. A follow up inspection will be completed to assess compliance with the QIP.

With regards to finance, adequate controls surrounding patients' finances were in place. Patients' financial records were up to date at the time of the inspection.

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.

To complete the inspection the following were reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. In relation to finance, a sample of patients' financial records was reviewed which included; records of transactions, records of patients' financial arrangements and records of patients' personal property. Controls surrounding the management of patients' monies and property were also reviewed. The inspectors spoke with staff and management about how they plan, deliver and monitor the management of medicines and patients' finances and property in the home.

4.0 What people told us about the service

On 24 January 2023 the pharmacist inspector met with two nurses, the deputy manager, and the manager and briefly with the responsible individual. On 25 January 2023 the finance inspector met with the manager and the home's administrator. 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, one response had been received by RQIA from a relative/visitor, which indicated that the respondent was very satisfied with the care provided.

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 24 August 2022		
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) **Stated:** First time	The registered person shall address the deficits with staff in receiving up-to-date training in first aid and safe moving and handling.	**Carried forward to the next inspection**
	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.	
Action required to ensure compliance with the Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4(3) **Stated:** First time	The registered person shall ensure patients' records have adequate social histories background information recorded.	**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.	

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.

Electronic 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 up to date. However, in line with safe practice, two members of staff should verify and sign the personal medication records each time they are written and updated to check their accuracy. An area for improvement was identified.

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 safe 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 for the management of distressed reactions was reviewed. Directions for use were recorded on the personal medication record; 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, infection and other factors. Records did not always include the reason for and outcome of each administration. It was agreed that staff would be reminded of this expected practice.

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. Two pain care plans required updating to reflect the current medication prescribed to manage pain. It was agreed that these would be updated following the inspection.

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.

The management of thickening agents and nutritional supplements were reviewed. 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.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined. 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. Daily fluid intake totals were not always recorded. It was agreed that staff would be reminded of this expected practice.

Care plans were in place when patients required insulin to manage their diabetes.

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 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. Staff were reminded that the refrigerator thermometer should be reset each day after recording temperatures.

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 electronic medicines administration records was reviewed. The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, discrepancies were observed in the administration of a small number of medicines including an inhaler preparation and an antibiotic. Some records of administration of evening medications, usually administered at around 10pm, were not completed until the early hours of the morning. Medicines must be administered as prescribed and an accurate and contemporaneous record of administration maintained. 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.

The date of opening was usually recorded on medicines so that they could be audited. This is good practice.

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the GP/community pharmacy as necessary.

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.

However, the findings of this inspection indicate that the auditing system has not been robust in recent months. Electronic records and actual stock balances did not correlate, indicating that incoming medicines and medicines administered 'when required', had not always been recorded appropriately (see also Section 5.2.3). An area for improvement was identified. In addition, the audit and governance of the management of medicines should be reviewed, to ensure that it is robust and includes the issues discussed in this report. An area for improvement was identified.

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.

There were records in place to show that staff responsible for medicines management had received training on the systems in place when they were implemented. However, annual competency assessments were not up to date and the outcomes of the inspection indicate that staff may need further training in the electronic medicines record system in use. An area for improvement was identified.

Medicines management policies and procedures were in place.

5.2.7 What arrangements are in place to ensure that patients' monies, valuables and personal property are appropriately managed and safeguarded?

A safe place was provided within the home for the retention of patients' monies and valuables. At the time of the inspection there were satisfactory controls around the physical location of the safe place and the members of staff with access to it. A review of a sample of patients' monies and valuables held at the home showed that the records were up to date at the time of the inspection.

Comfort fund monies were also held on behalf of patients, these are monies donated to the home for the benefit of all patients. A review of a sample of transactions from the comfort fund confirmed that records were up to date and that purchases from the fund were for the benefit of all patients.

A sample of records evidenced that reconciliations (checks) of monies and valuables held on behalf of patients 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. Good practice was observed as in addition to the monthly reconciliations finance audits were completed on a quarterly basis. Spot checks on patients' monies and transactions, undertaken on behalf of patients, were included in the audit.

Discussion with staff confirmed that no bank accounts were used to retain patients' monies and no member of staff was the appointee for any patient, namely a person authorised by the Department for Communities to receive and manage the social security benefits on behalf of an individual.

Three patients' finance files were reviewed. Written agreements were retained in all three files. The agreements included the details of the current weekly fee paid by, or on behalf of, the patients and a list of services provided to patients as part of their weekly fee. A list of services available to patients at an additional cost, such as hairdressing, was also included within the agreements. The agreements were signed by the patient, or their representative, and a representative from the home.

Review of records and discussion with staff confirmed that all patients' weekly fees, including third party payments, were paid to the home by the health and social care trusts. Discussion with staff confirmed that patients were not paying an additional amount towards their fee over and above the amount agreed with the health and social care trusts.

A sample of records of payments to the hairdresser and podiatrist was reviewed. The records were up to date at the time of the inspection. The records were signed by the hairdresser and podiatrist and countersigned by a member of staff to confirm that the treatments took place.

A sample of records of monies deposited at the home on behalf of two patients was reviewed. Records were up to date at the time of the inspection. The person depositing the monies signed the records along with a member of staff.

A sample of two patients' files evidenced that property records were in place for both patients. The records were updated with additional items brought into patients' rooms and when items were disposed of. The records were checked and signed by two members of staff at least quarterly.

Policies and procedures for the management and control of patients' finances were available for inspection. The policies were readily available for staff use. The policies were up to date and reviewed at least every three years.

Discussion with staff confirmed that no transport scheme was in place at the time of the inspection.

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 the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	3*	4*

* 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 Mr Seon MacStiofain, Registered Manager and Ms Ema Braga, Deputy Manager, 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 Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 20(1)(c) **Stated:** First time **To be completed by:** 24 October 2022	The registered person shall address the deficits with staff in receiving up-to-date training in first aid and safe moving and handling. **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:** Immediately and ongoing (24 January 2023)	The registered person shall ensure that medicines are administered as prescribed and an accurate and contemporaneous record of administration maintained. Ref: 5.2.3 **Response by registered person detailing the actions taken**: All staff have received further supervision and training on the recording of medications as a contemporianious record immediately after the administration of the medications,late medications are recorded within the system with an explanation attachment.Further support for the administration of medications at night time are being reviewed with the intention of reintroducing a twlight Nursing component to our staffing compliment.
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** Immediately and ongoing (24 January 2023)	The registered person shall ensure that all medicines received are recorded appropriately. Ref: 5.2.5 **Response by registered person detailing the actions taken**: All Medication electronic kardex's have been audited to ensure that they are checked,signed and recorded approperiately,with amendments as necessary. All Medication Audits incorporate new Medication management and recording of New Medications added during the monthly cycle.

<table>
<tr><th colspan="2">Action required to ensure compliance with the Care Standards for Nursing Homes, April 2015</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 4(3)

Stated: First time

To be completed by:
24 September 2022</td><td>The registered person shall ensure patients’ records have adequate social histories background information recorded.</td></tr>
<tr><td>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</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 29

Stated: First time

To be completed by:
Immediately and ongoing
(24 January 2023)</td><td>The registered person shall ensure that two members of staff verify and sign the electronic personal medication records each time they are written and updated to check their accuracy.

Ref: 5.2.1</td></tr>
<tr><td>Response by registered person detailing the actions taken:
All Nursing Staff have received supervision and training in the recording of medications delivery.All medications are received by two nurses and signed approperiatly.This issue is under review within our auditing process.</td></tr>
<tr><td rowspan="2">Area for improvement 3

Ref: Standard 28

Stated: First time

To be completed by:
Immediately and ongoing
(24 January 2023)</td><td>The registered person shall ensure that the audit and governance of the management of medicines is reviewed, to ensure that it is robust and includes the issues discussed in this report.

Ref: 5.2.5</td></tr>
<tr><td>Response by registered person detailing the actions taken:
The home is operating an indepth auditing process to identify discrepencies in the recording of PRN and boxed medications. We have identified the issues which have lead to discrepencies and have piloted a auditing count sheet within the Electronic Medication system to identify discrepencies at an early stage. All staff are aware of these issues through supervision and recent updating of Pillpac Training.</td></tr>
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Area for improvement 4 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 24 February 2023	The registered person shall ensure that training is updated as necessary and annual competency assessments are completed for staff responsible for the management of medicines. Ref: 5.2.6
	Response by registered person detailing the actions taken: All Qualified Staff have received updated training in the management and administrations of medications using our Pillpac electronic medication administration system. Staff are receiving annual competency and capability assessments by our registered pharmacist . Our Clinical Nurse Lead and Nursing Sister are to receive further training in the completion of medication competency assessments going forward.

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

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