The Regulation and Quality Improvement Authority

Inspection Report

16 April 2024

Fruithill Nursing Home

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 Limited **Responsible Individual:** Mr Paul McGranaghan	**Registered Manager:** Mrs Catherine Lenaghan - registration pending
Person in charge at the time of inspection: Mrs Catherine Lenaghan	**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 LD – learning disability TI – terminally ill	**Number of patients accommodated in the nursing home on the day of this inspection:** 36
Brief description of the accommodation/how the service operates: Fruithill Nursing Home is a nursing home registered to provide nursing care for up to 36 patients. Accommodation is over two floors with communal dining and sitting areas on the ground floor.	

2.0 Inspection summary

An unannounced inspection took place on 16 April 2024, from 9.50am to 3.40pm. 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 area for improvement identified at the last care inspection will be followed up at the next care inspection.

The majority of medicine records and medicine related care plans were well maintained, continuing improvement was evident and this was acknowledged with staff. Two areas for

improvement were identified, these are detailed in the quality improvement plan and include the completion of records of administration of medicines prescribed for use 'when required' and monitoring the administration of inhaler preparations.

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

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 regarding the management of medicines.

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. Discussions were held about how staff and management 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 said that they had the appropriate training to look after patients and meet their needs. Nurses and the manager stated they had worked hard to improve the management of medicines and that the changes implemented since the last medicines management inspection had been effective and were sustainable.

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 responses 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 12 March 2024		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 16(1) **Stated:** First time	The registered person must put in place a care plan for the identified patient's assessed need with adequate evaluation of care and progress.	**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.	
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** Third time	The registered person shall ensure that medicines are administered as prescribed and an accurate and contemporaneous record of administration maintained.	**Met**
	Action taken as confirmed during the inspection: Significant improvement was evident and this area for improvement was assessed as met (see section 5.2.3).	
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 28 **Stated:** Third time	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.	**Met**
	Action taken as confirmed during the inspection: Significant improvement was evident and this area for improvement was assessed as met (see section 5.2.3).	

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 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.

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 for distressed reactions was reviewed. 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 and other factors. Records did not always include the reason for and outcome of each administration, this had been raised during the homes own auditing procedures for a variety of medicines prescribed on a 'when required' basis. An area for improvement was identified.

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 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. The manager agreed to review care plans to ensure they match the current regimen regarding the daily fluid target. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside the recommend range.

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

Medicine 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 medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was 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 if the refrigerator temperature falls below the recommended range this should be escalated to management for action and that the refrigerator in use should be defrosted on a regular basis. The temperature was within range at the time of the inspection.

Satisfactory arrangements were in place for the safe disposal of medicines. Staff were reminded that each entry in the medicines disposal book must be signed by the two staff involved.

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 medicine 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 monitoring. There was evidence that the records had been maintained contemporaneously and the majority of medicines were administered as prescribed. See Section 5.2.5.

The audit and governance systems for medicines had been reviewed to ensure that all aspects of medicines management were included. Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. When discrepancies were identified these were followed up. The date of opening was recorded on the majority of medicines so that they could be easily audited.

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.

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 community pharmacy. Medicine records had been accurately completed.

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 incident which had been reported to RQIA since the last inspection was

discussed. 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.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines including inhaler preparations. These were highlighted to the manager for monitoring. 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 been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

It was agreed that the findings of this inspection would be shared with staff for ongoing improvement.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Care Standards for Nursing Homes, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	1*	2

* the total number of areas for improvement includes one that has been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Catherine Lenaghan, Manager, as part of the inspection process. The timescale for completion commences 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 16(1) **Stated:** First time **To be completed by:** 19 March 2024	The registered person must put in place a care plan for the identified patient's assessed need with adequate evaluation of care and progress. **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
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 18 **Stated:** First time **To be completed by:** From the date of the inspection onwards (16 April 2024)	The registered person shall ensure that the reason for and outcome of each administration, is recorded for medicines prescribed on a 'when required' basis. Ref: 5.2.1 **Response by registered person detailing the actions taken:** Nurses to document effects of "when requires" medication in the electronic MARS and respective residents daily report.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** From the date of the inspection onwards (16 April 2024)	The registered person shall ensure that the administration of medicines with identified discrepancies, including inhaler preparations, is monitored within audit procedures. Ref: 5.2.5 **Response by registered person detailing the actions taken:** Audit of regular inhaler administration included in Monthly audit schedule.

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