Inspection Report

30 October 2023

Hawthorn House

Type of Service: Nursing Home
Address: 16-16a Hawthornden Road, Belfast, BT4 3JU
Tel No: 028 9047 3027

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: Beaumont Care Homes Ltd **Responsible Individual:** Mrs Ruth Burrows	**Registered Manager:** Miss Rachel Downing **Date registered:** 20 June 2022
Person in charge at the time of inspection: Miss Rachel Downing	**Number of registered places:** 32
Categories of care: Nursing Home (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.	**Number of patients accommodated in the nursing home on the day of this inspection:** 30
Brief description of the accommodation/how the service operates: Hawthorn House is a registered nursing home which provides nursing care for up to 32 patients. The home is divided over two floors. Patients have access to communal lounges, a dining room and a garden area.	

2.0 Inspection summary

An unannounced inspection took place on 30 October 2023, from 10.30am to 2.15pm. This was completed by a pharmacist inspector and 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 for review at the next care inspection.

Review of medicines management found that medicine records and medicine related care plans were well maintained. Medicines were stored safely and securely. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines. One new area for improvement in relation to ensuring patients have a continuous supply of their prescribed medicines was identified.

Whilst one area for improvement was 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 to 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 care staff, nursing staff and the manager. 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 11 January 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 21 (1) (b) **Stated:** First time	The registered person shall ensure that the system for monitoring staffs' professional registration is sufficiently robust to ensure relevant staff do not work unregistered and evidence is maintained of actions taken when anomalies are identified. **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 the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that supplementary records are maintained up to date, accurate, and in a contemporaneous manner. This is in relation to but not limited to, repositioning records, bedrail checks, and night checks. **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**
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that records pertaining to hydration management are individualised. This is with specific reference to patients whose fluid intake regularly falls below what is recommended for an adult. Daily progress records should evidence review of fluid intake by a nurse. **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.

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 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. These medicines were administered infrequently. On occasions when they were administered, records included the reason for and outcome of each administration.

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 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.

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 recommended 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 the majority of medicines were available for administration when patients required them. However, it was identified that a small number of medicines had been out of stock which resulted in missed doses. Review of records for a number of patients recently admitted to the home identified a number of medicines were out of stock after the initial supply of medicines brought in from hospital had run out. These discrepancies were highlighted to the manager on the day of inspection. Patients must have a continuous supply of their prescribed medicines as missed doses or late administrations can impact upon their health or well-being. An area for improvement was identified.

The medicines 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.

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

Several patients have their medicines administered in food/drinks to assist administration. Care plans detailing how the patients like to take their medicines were in place. Some of the practices followed by staff to assist administration mean that medicines are being administered outside the terms of their product licence. This means that the way the medicine is given has been changed to meet the need to the patient. While this is appropriate for most patients, this practice should be checked to ensure that the patient's GP agrees. Written authorisation had been obtained 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.

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. The 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 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.

The audits completed at the inspection indicated that the large majority of medicines were being administered as prescribed. As discussed in Section 5.2.2, a number of missed doses occurred as medicines were out of stock.

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.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has 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*	3*

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

The new area for improvement and details of the Quality Improvement Plan were discussed with Miss Rachel Downing, Registered 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 21 (1) (b) **Stated:** First time **To be completed by:** With immediate effect (11 January 2023)	The registered person shall ensure that the system for monitoring staffs' professional registration is sufficiently robust to ensure relevant staff do not work unregistered and evidence is maintained of actions taken when anomalies are identified. **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 4 **Stated:** First time **To be completed by:** With immediate effect (11 January 2023)	The registered person shall ensure that supplementary records are maintained up to date, accurate, and in a contemporaneous manner. This is in relation to but not limited to, repositioning records, bedrail checks, and night checks. **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:** 25 January 2023	The registered person shall ensure that records pertaining to hydration management are individualised. This is with specific reference to patients whose fluid intake regularly falls below what is recommended for an adult. Daily progress records should evidence review of fluid intake by a nurse. **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 3 **Ref:** Standard 28 **Stated:** First time	The registered person shall ensure patients have a continuous supply of their prescribed medicines. This is in particular reference to patients recently admitted to the home. Ref: 5.2.2
To be completed by: With immediate effect (30 October 2023)	**Response by registered person detailing the actions taken**: An admission audit will be completed by the Home Manager for all new residents on day 5 post admission. This includes the check to ensure that a copy of the discharge letter has been sent to GP, that the resident has been registered with Boots Care Services and if the order for monthly medication has been submitted to the GP. An action plan will be shared with the nursing staff to action any deficits found following completion of this audit. All nursing staff have been advised to inform the Home Manager of any issues that arise with this process in order to avoid potential out of stock medications occurring. The Home Manager will advocate on their behalf with GP surgery and Boots if issues are arising. The Home Manager and RN staff met with Boots Care Services on 2nd November 2023, and it was agreed that if any issues arose, the Home Manager and Supervisor from Boots will communicate directly in order to rectify. The Home Manager will continue to monitor stock levels via the monthly Medication Audit and this will be validated by the Operations Manager during the Monthly Regulation 29 Visit.

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

The Regulation and Quality Improvement Authority

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