Unannounced Medicines Management Inspection Report
27 April 2016

Hawthorn House

16-16a Hawthornden Road, Belfast, BT4 3JU
Tel No: 028 9047 3027
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Hawthorn House took place on 27 April 2016 from 10:35 to 15:00.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The management of medicines supported the delivery of safe, effective and compassionate care and the service was found to be well led in that respect. The outcome of the inspection found no areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

Is care safe?
One recommendation has been stated for a second time.

Is care effective?
Two recommendations have been made; one of these has been stated for a second time.

Is care compassionate?
No requirements or recommendations have been made.

Is the service well led?
No requirements or recommendations have been made.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to the DHSSPS Nursing Homes Minimum Standards, February 2008. RQIA will continue to monitor any recommendations made under the 2008 standards until compliance is achieved. Please also refer to Sections 4.2 and 5.0 of this report.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	3

Details of the QIP within this report were discussed with Ms Kerrie Wallace, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the most recent inspection dated 20 January 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/ Dr Maureen Claire Royston	**Registered manager:** Ms Kerrie Wallace
Person in charge of the home at the time of inspection: Ms Kerrie Wallace	**Date manager registered:** 30 June 2010
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 32

3.0 Methods/processes

Prior to inspection the following records were analysed:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection

We met with two patients, two members of care staff, one registered nurse and one patient's relative.

The following records were examined:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 20 January 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 23 July 2013

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** Third time	Obsolete personal medication records must be archived.	**Met**
	Action taken as confirmed during the inspection: Only the current personal medication records were held in the folder. Obsolete records had been archived.	
Requirement 2 **Ref**: Regulation 13(4) **Stated:** Second time	Administration of thickening agents by care assistants must be recorded appropriately.	**Met**
	Action taken as confirmed during the inspection: Care assistants had recorded the administration of thickening agents on fluid intake charts. These charts were reviewed within the audit process.	
Requirement 3 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager is required to closely monitor the administrations of the six medicines that produced unsatisfactory audit outcomes, in order to ensure compliance with the prescribers' instructions.	**Met**
	Action taken as confirmed during the inspection: The registered manager advised that the frequency of auditing on these medicines had been increased following the inspection. These included eye drops, nutritional supplements and inhaled medicines. There continued to be monitoring arrangements in place for these medicines.	

Requirement 4 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must ensure that there are robust arrangements in place for monitoring the administration of medicines and for addressing any issues arising from this audit activity.	**Met**
	Action taken as confirmed during the inspection: The auditing systems for medicines management had been reviewed. Any discrepancies were reported to the registered manager and investigated. The outcomes were shared with staff.	
Requirement 5 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must ensure that medicines for disposal are securely stored.	**Met**
	Action taken as confirmed during the inspection: Medicines for disposal were securely stored.	
Last medicines management inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 37, 38 **Stated:** First time	Two nurses should always witness the disposal of medicines into the clinical waste bins and record this activity.	**Not Met**
	Action taken as confirmed during the inspection: Two trained staff were not involved in the disposal of medicines. Occasionally one staff signature was recorded in the disposal record. This recommendation was not met and has been stated for a second time.	
Recommendation 2 **Ref**: Standard 38 **Stated:** First time	The route of administration of eye-treatment medicines should be routinely recorded on the personal medication record sheets.	**Not Met**
	Action taken as confirmed during the inspection: The route of administration of eye preparations was not recorded on the sample of personal medication records examined. This recommendation was not met and has been stated for a second time.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for registered nurses and for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Medicines management training was provided through attendance at training sessions and the completion of e-learning modules; refresher training was planned for June 2016.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. Most of the updates on personal medication records and all of the handwritten entries on medication administration records were signed by two registered nurses. The registered manager agreed to raise this with staff.

There were procedures in place to ensure the safe management of medicines during a patient's admission to the home and discharge from the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were removed from use and uplifted by a waste disposal company. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. In relation to the disposal of medicines records, there was no evidence that two trained staff had been involved in the disposal. A recommendation was stated for a second time.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Medicine refrigerators and oxygen equipment were checked at regular intervals. It was noted that occasionally some of the recorded medicine refrigerator temperatures were outside the accepted temperature range for medicines which require cold storage. The registered manager advised that this would be addressed.

Areas for improvement

The record keeping in relation to the disposal of medicines should be reviewed. The recommendation made at the last medicines management inspection was stated for a second time.

Number of requirements	0	Number of recommendations	1

4.4 Is care effective?

The majority of medicines examined had been administered in accordance with the prescriber's instructions. Some discrepancies were identified and discussed with the registered manager. It was agreed that additional monitoring arrangements for these medicines would be implemented from the day of the inspection onwards.

It was noted that bisphosphonate medicines which were required to be administered separately from other medicines, had been administered with other medicines. This was discussed and the registered manager advised that this had been identified within a recent audit and she provided details of the corrective action planned.

There were arrangements in place to alert staff of when doses of weekly or three monthly medicines were due.

When a patient was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, dosage instructions were recorded on the personal medication record. A care plan was maintained. These medicines were infrequently administered. The reason for and the outcome of the administration were not recorded. This was discussed and it was agreed that this would occur from the day of the inspection onwards. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Staff advised that most of the patients could verbalise any pain, and a pain assessment tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment was completed as part of the admission process.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record and included details of the prescribed fluid consistency. Each administration was recorded and a care plan and speech and language assessment report was in place.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the patient's health were reported to the prescriber.

Whilst most of the medicine records were well maintained and facilitated the audit process, some areas for improvement were noted in the personal medication records. A recommendation was made. Details of the administration instructions for eye preparations were not fully recorded and a recommendation was stated for a second time.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for some medicine which were not supplied in the 28 day blister packs. The registered manager provided details of a specific audit tool which had been implemented to ensure that all patients' medicines were audited. A daily quality of life audit tool was also used to ensure that medicines had been administered and recorded. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to issues or concerns regarding medicines management.

Areas for improvement

The maintenance of personal medication records should be reviewed to ensure these are kept up to date at all times and maximum daily dosages are recorded for medicines prescribed on a "when required" basis. A recommendation was made.

The prescribed administration instructions for eye preparations should be detailed on the personal medication records. A recommendation was stated for a second time.

Number of requirements	0	Number of recommendations	2

4.5 Is care compassionate?

It was found that the administration of medicines to patients was completed in a caring manner. Patients were given time to take their medicines and medicines were administered as discreetly as possible.

Patients advised that they were administered their medicines on time, staff responded to their requests for medicines which were prescribed on a "when required" basis and they had no concerns regarding their medicines.

The visitor spoken to at the inspection advised that they were content with the management of medicines for their relative.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Written policies and procedures for the management of medicines were in place. These had been updated in March 2016. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. The medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and the learning implemented following incidents.

A review of the internal records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the registered manager, registered nurses and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Not all recommendations made at the last medicines management inspection had been addressed effectively. To ensure that these are fully addressed and the improvement sustained, it was suggested that the QIP should be used as a part of the audit process.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated with staff at handover, at team meetings or individually with staff. The registered manager advised of the medicine management agenda items for the staff meeting which was held on the day of the inspection.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Kerrie Wallace, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and the DHSSPS Care Standards for Nursing Homes (2015). They promote current good practice and if adopted by the registered person(s) may enhance service, quality and delivery.

5.3 Actions taken by the registered manager/registered person

The QIP will be completed by the registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed by the registered manager. Once fully completed, the QIP will be returned to pharmacists@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered person/manager from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered person/manager with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Recommendations	
Recommendation 1 **Ref**: Standard 37 & 38 **Stated:** Second time **To be completed by:** 23 May 2016	Two nurses should always witness the disposal of medicines into the clinical waste bins and record this activity.
	Response by registered person detailing the actions taken: Supervision completed with all RN staff 19.5.16 Manager to monitor during weekly audits
Recommendation 2 **Ref:** Standard 38 **Stated:** Second time **To be completed by:** 23 May 2016	The route of administration of eye-treatment medicines should be routinely recorded on the personal medication record sheets.
	Response by registered person detailing the actions taken: Supervision completed with all RN staff 19.5.16 Manager to monitor during weekly audits
Requirement 3 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 23 May 2016	The necessary arrangements should be made to ensure that personal medication records are fully and accurately maintained at all times.
	Response by registered person detailing the actions taken: Supervision completed with all RN staff 19.5.16 Audit tool in place for RN staff to verify monthly that records are accurate Manager to monitor during weekly audits

The Regulation and Quality Improvement Authority

9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews