Unannounced Follow Up Medicines Management Inspection Report
9 July 2018

Hawthorn House

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

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 service provider from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a nursing home with 32 beds that provides care for patients living with a range of healthcare needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual**: Dr Maureen Claire Royston	**Registered Manager:** See below
Person in charge at the time of inspection: Mrs Joanne Roy	**Date manager registered:** Mrs Joanne Roy (Acting - no application required)
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 registered places:** 32

4.0 Inspection summary

An unannounced inspection took place on 9 July 2018 from 10.10 to 16.10.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005/ the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

Since March 2018 there has been an increase in the number of medicine related incidents reported to RQIA. In June 2018 we received information from the Belfast Health and Social Care Trust in addition to information received via the RQIA duty desk regarding staffing within the home. Following the outcome of the care inspection undertaken as a result of the information on 5 July 2018, an unscheduled medicines management inspection took place.

This inspection sought to determine if there were robust arrangements in place for the management of medicines and if the service was delivering safe, effective and compassionate care and if the service was well led.

The following specific areas were examined during the inspection:

- administration of medicines
- medicine records and care plans
- storage
- governance

The inspection findings indicated that there were examples of good practice in relation to the completion of personal medication records and management of medicine changes; however, the robust arrangements evidenced at the last medicines management inspection in April 2017 had not been sustained. Areas for improvement were identified in relation to record keeping, administration, storage and care planning.

We observed the patients to be content in their surroundings and interactions with staff.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	3	5

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Joanne Roy, 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.

4.2 Action/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 5 July 2018. The outcome of this inspection found breaches with the regulations regarding the health and welfare of patients and staffing arrangements in the home. Following a meeting with the representatives of the registered person, two failure to comply notices were served on 11 July 2018. The compliance date for both is 22 August 2018.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following:

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

During the inspection the inspector met with two registered nurses, one care assistant, the registered manager and also with the regional manager at the end of the inspection.

A poster was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

A sample of the following records was examined during the inspection:

- 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

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 5 July 2018

The most recent inspection of the home was an unannounced care inspection. The report was issued to the registered provider on 1 August 2018. Enforcement action resulted from this inspection see Section 4.2

6.2 Review of areas for improvement from the last medicines management inspection dated 25 April 2017

There were no areas for improvements made as a result of the last medicines management inspection.

6.3 Inspection findings

Administration of medicines

Most of the audit trails on the medicines selected for examination produced largely satisfactory outcomes. These included a variety of medicines which were not supplied in the 28 day blister packs. The administration of those medicines which should be closely monitored were highlighted to staff and the manager. It was agreed that these would be included in the audit process.

At the care inspection on 5 July 2018, concerns had been raised in relation to the administration of medicines for diabetes and oxygen. Following discussion with staff and the manager and a review of the medicine records, we found that that the issues raised had been addressed and were being closely monitored. See also section on medicine records and care plans below.

We noted an apparent discrepancy regarding eye preparations; it could not be clarified what eye preparation was currently prescribed for one patient. An area for improvement was identified.

Medicine records and care plans

Some of the medicine records examined were well maintained and facilitated the audit process. There was evidence of good practice such as maintaining separate administration records for high risk medicines, patches and pain relief. Following the recent care inspection, new documentation regarding the administration of insulin, oxygen and blood monitoring had been developed and implemented.

Written confirmation of medicine regimes was received for new patients' medicines and changes to warfarin dosage regimes. Personal medication records had been written and verified by two staff and additional information was initialled by two staff. This is good practice with regard to the safe management of new medicines and medicine changes; however, this did not routinely occur when transcribing medicines information on medication administration records. An area for improvement was identified.

The administration of external preparations requires further review. A number of these were administered by care staff. Registered nurses had coded the records to indicate that the task was delegated to care staff; however, as there was no system in place for care staff to record administration, we were unable to evidence that a robust system to manage this delegated task was in place. We spoke with the care assistant and registered nurse and both assured us that these medicines were being administered. An accurate record of all administered medicines must be maintained. An area for improvement was identified.

On occasion we noted that the handwriting was difficult to read. All records should be legible. It was agreed that this would be discussed with the staff.

The outcomes of the recent care inspection indicated that the morning medicines round took several hours with the medicines round for patients on the ground floor only commencing at 11.00. This had been attributed to only one registered nurse being on duty who was fully trained in medicines management. At 10.45 during this medicines management inspection, the first floor medicines had been administered; and on the ground floor, the registered nurse advised there were three patients' yet to receive their medicines. We reviewed the administration records and although these medicines had been administered between two and three hours after the time printed (08.30) on the medication administration records, staff had routinely signed administration of morning medicines as 08.30. It was noted that medicines prescribed earlier in the morning were administered and recorded accurately. The actual time of administration must be accurately completed to ensure that the time intervals between doses are known and adhered to. The administration of medicines should be reviewed to ensure that these are administered on time, the times on the medication administration records are reflective of practice and in the instances were these are delayed, this is clearly recorded on the administration records. An area for improvement was identified.

A sample of care plans in relation to medicines management was reviewed. Some of these were maintained in a satisfactory manner, e.g. pain management, warfarin; and some had been recently developed regarding diabetes and oxygen, as a result of the recent care inspection. During this medicines management inspection we noted that a few care plans regarding the refusal of medicines, distressed reactions, antibiotics and crushing of medicines required to be developed or needed additional information. An area for improvement was identified.

Storage

Medicines were stored safely and securely. Key control was appropriate. The date of opening was routinely recorded on medicines with a limited shelf-life once opened e.g. eye preparations and insulin pen devices.

It was noted that the daily room temperature of the first floor treatment room was frequently above 25^{o}C, with up to 32^{o}C recorded; it was 30^{o}C during the inspection. Although the door was open and an electric fan was in place, this was not effective in reducing the temperature. The manager advised that an air conditioning unit had been requested, but it could not be confirmed if or when this was to be installed. All medicines must be stored at or below 25^{o}C or in accordance with the manufacturer's instructions. An area for improvement was identified.

We also noted that space in the medicine cupboards was limited and did not readily facilitate adequate segregation of each patient's medicines. The manager advised that the stock control was being reviewed and a request had been made for a full refurbishment of the treatment room. No further details were available.

In relation to infection prevention and control it was observed that single use syringes were being washed for reuse. This was highlighted with the manager and she advised that this would be addressed with the registered nurse immediately.

Some patients' medicines were supplied in seven day domiciliary packs. Two of these packs were not clearly labelled to identify the medicine by code, colour and/or shape. All medicines should be clearly identifiable. An area for improvement was identified.

Governance

Since the last medicines management inspection, there had been changes in staff and management in the home and we were advised that further management changes were planned.

One of the outcomes of the recent care inspection was that to ensure the safe management of patients and to meet the patient's nursing needs, the number of registered nurses on duty should be increased. This had been escalated within the organisation at that time and addressed the same evening. Two registered nurses were on duty at the time of this medicines management inspection.

The manager confirmed that staff received training in medicines management annually as part of the organisation's policies and procedures. She advised that there were systems in place to complete staff appraisals; but stated that these were overdue. We were advised that senior management were aware of this. Competency assessments were also completed annually and records for two registered nurses were made available at the inspection. However, the outcomes of the care inspection showed deficits in the quality of care in relation to the management of diabetes and oxygen. As a result, training and supervision sessions were completed on 6 July 2018.

In the last four months, there had been an increase in the frequency of medicine related incidents reported to RQIA. Several of these included high risk medicines and were discussed with the manager. The manager advised that most of these involved non-permanent staff; she

confirmed there was a system to ensure that all agency nurses received induction. She further advised of the systems in place to share learning from incidents and to prevent recurrence. There was evidence that two staff were involved in transcribing warfarin dosage regimes and administering warfarin and insulin. Medicines which were administered at weekly intervals were clearly highlighted on the administration records to remind staff when the next dose was due. There was evidence of the recent implementation of daily monitoring of insulin and oxygen administration records.

We were advised of the auditing processes in place for medicines management. A sample of auditing records was reviewed. Whilst there were a variety of audits completed, on occasion there was limited evidence to indicate that issues were followed up appropriately or that the most recent monthly monitoring report in June 2018 included medicines management. An area for improvement was identified.

Areas of good practice

There were examples of good practice in relation to the general administration of medicines, the completion of personal medication records and the management of medicine changes and the management of medicine incidents.

Areas for improvement

The manager should review the management of one patient's eye preparations and forward a written report of the findings and action taken.

Two staff should be involved in the transcribing of medicine information onto medication administration records.

The management of external preparations must be reviewed.

The administration of medicines should be reviewed to ensure that these are administered on time, the times on medication administration records are reflective of practice and in the instances were these are delayed, this is clearly recorded on the administration records.

Patient care plans should be reviewed as necessary to reflect the management of their medical condition.

The storage of medicines should be reviewed to ensure that they are stored in accordance with the manufacturers' instructions.

The necessary arrangements should be made to ensure that all medicines are clearly labelled and identifiable.

The auditing processes should be further developed to ensure that they are effective.

	Regulations	Standards
Total number of areas for improvement	3	5

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Mrs Joanne Roy, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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 the nursing home. 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.

7.1 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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 9 August 2018	The registered person shall review the management of eye preparations as identified at the inspection and provide details of the findings and action taken. Ref: 6.3
	Response by registered person detailing the actions taken: A thorough review of all eye medication took place in the Home and all prescribed medication is labelled correctly with the date of opening documented, and the medications are all administered as prescribed by the GP. Compliance will be monitored via the monthly medication audit.
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 9 August 2018	The registered person shall ensure that records of the administration of external preparations are fully and accurately maintained. Ref: 6.3
	Response by registered person detailing the actions taken: The Care Assistants have undertaken further training on the TMAR system and are using it to detail the application of creams and lotions that they administer to residents as directed by the Nurses. Compliance will be monitored via the auditing process.
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** 9 August 2018	The registered person shall make the necessary arrangements to ensure that the treatment room temperature is maintained at or below 25^{o}C and medicines are stored in accordance with the manufacturers' instructions. Ref: 6.3
	Response by registered person detailing the actions taken: An air conditioning unit was installed on 20th August and is maintaining the treatment room at an appropriate temperature below 25degrees. Compliance will be monitored via the auditing process.

Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015

Area for improvement 1 **Ref**: Standard 29	The registered person shall ensure that all transcribing on medication administration records involves two staff and both staff sign the entry.

Stated: First time **To be completed by:** 9 August 2018	Ref: 6.3
	Response by registered person detailing the actions taken: Staff have been reminded of the need for double signatures when transcribing medications.A full review of the medicine kardexs is being undertaken to ensure compliance. Compliance will also be montiored via the auditing process.

Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 9 August 2018	The registered person shall review the process for the administration of medicines as detailed in the report. Ref: 6.3
	Response by registered person detailing the actions taken: Two nurses are now on duty throughout the day from 8am-8pm, this allows for timely administration of medications as they are prescribed. Staff are aware of the need to accurately document when medications are administered and this is again checked through daily audits and has been raised at staff meetings and supervisions.
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 9 August 2018	The registered person shall review the care plans in relation to medicines management to ensure that these reflect the patient's needs, as detailed in the report. Ref: 6.3
	Response by registered person detailing the actions taken: Care plans are in place, for all residents who are administered medication, and they are specific to each residents requirements. Staff are aware of the need to put in place care plans when antibiotics are prescribed and this is checked by Home Manager. There are care plans in place for refusal of medications for all residents.
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time **To be completed by:** 9 August 2018	The registered person shall ensure that all medicines are clearly identifiable. Ref: 6.3
	Response by registered person detailing the actions taken: All medicines are clearly labelled with residents details and staff know, through training and supervison, they are not to accept medications which are not correctly labelled.
Area for improvement 5 **Ref**: Standard 28	The registered person shall further develop the auditing processes for medicines management to ensure that they are effective. Ref: 6.3

Stated: First time **To be completed by:** 9 August 2018	
	Response by registered person detailing the actions taken: There is a daily medication audit of a different resident each day of the month. A matrix is in place to ensure that each resident is therefore reviewed at least monthly.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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

Assurance, Challenge and Improvement in Health and Social Care