Unannounced Medicines Management Inspection Report
25 April 2017

Hawthorn House

Type of Service: Nursing Home
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 25 April 2017 from 10.05 to 14.45.

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.

Is care safe?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for patients. Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. No requirements or recommendations were made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Care plans for areas of medicines management were maintained. No requirements or recommendations were made.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for patients. Patients confirmed that they were administered their medicines appropriately. No requirements or recommendations were made.

Is the service well led?

The service was found to be well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. No requirements or recommendations were 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.

1.1 Inspection outcome

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

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Mrs Kerrie Wallace, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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 QIP there were no further actions required to be taken following the most recent inspection on 11 August 2016.

2.0 Service details

Registered organisation/registered person: Four Seasons Healthcare/ Dr Maureen Claire Royston	**Registered manager:** Mrs Kerrie Wallace
Person in charge of the home at the time of inspection: Mrs 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 incidents register – it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

We met with two patients, one member of care staff, two registered nurses and the registered manager.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

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

Fifteen questionnaires were issued to patients, their relatives/representatives and staff, with a request that these were completed and returned to RQIA within one week of the inspection.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 11 August 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector. This QIP will be validated by the care inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection 27 April 2016

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 37 & 38 **Stated:** Second time	Two nurses should always witness the disposal of medicines into the clinical waste bins and record this activity.	**Met**
	Action taken as confirmed during the inspection: Examination of the disposal of medicines records indicated that two registered nurses were involved in the disposal of medicines. Controlled drugs were denatured prior to disposal.	
Recommendation 2 **Ref:** Standard 38 **Stated:** Second time	The route of administration of eye-treatment medicines should be routinely recorded on the personal medication record sheets.	**Met**
	Action taken as confirmed during the inspection: Full details of the dose and route of administration of eye preparations was recorded on the patients' personal medication records examined.	

Requirement 3 **Ref:** Standard 29 **Stated:** First time	The necessary arrangements should be made to ensure that personal medication records are fully and accurately maintained at all times.	**Met**
	Action taken as confirmed during the inspection: Most of the personal medication records selected for examination were well maintained. Staff were aware that some of these required rewriting and this process had commenced. On occasion, a second member of staff had not verified updates to this record. The registered manager advised that this had been identified and would be raised with all staff and included in management audits.	

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. There was a training programme in place. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually.

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. Suitable arrangements were in place for the acquisition and storage of prescriptions.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Antibiotics and new medicines had been received and commenced in a timely manner. Most of the personal medication records and handwritten entries on medication administration records were updated by two registered nurses. Staff were reminded that all updates to personal medication records should be signed by two staff (see Section 4.2).

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.

The management of high risk medicines was examined. Medicine dosage regimes were confirmed in writing and the transcribing of medicines information was undertaken by two registered nurses. This is safe practice.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal.

Medicines were stored safely and securely and mostly in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Medicine refrigerators and oxygen equipment were checked at regular intervals. The records of refrigerator temperatures indicated that the minimum temperature was often below 2^{o}C. There was no ice formed in this refrigerator and it was concluded that there may be a fault with the thermometer. The need to ensure that staff report any deviation in temperatures was discussed. The registered manager advised that this was a new medicines refrigerator and that the thermometer and refrigerator would be checked with immediate effect and also discussed with staff.

There were largely satisfactory systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened e.g. eye drops, insulin and nutritional supplements. However, the date of opening was not recorded on the two different insulin pens in current use and one was not labelled. It was acknowledged that from the dose prescribed, the insulin pens would be finished before the in-use expiry date was reached. Staff advised that these insulin pens were opened earlier in the week. The need to ensure that the date was recorded was discussed. The registered nurse labelled the insulin pen during the inspection.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.4 Is care effective?

The sample of medicines examined had been administered in accordance with the prescriber's instructions.

There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly medicines and injectable medicines were due.

Satisfactory arrangements were in place for the management of pain, swallowing difficulty and distressed reactions.

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.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included the use of separate administration records for transdermal patches and warfarin; in addition paracetamol warnings were recorded when two medicines containing paracetamol were prescribed for the same patient.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to patient's healthcare needs.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

The administration of medicines to patients was not observed at this inspection. Staff confirmed that the patients were given time to take their medicines and were administered medicines in their preferred location, i.e. bedroom, dining room or lounge.

Throughout the inspection, it was found that there were good relationships between the staff and the patients. Staff were noted to be friendly and courteous; they treated the patients with dignity. It was clear that the staff were familiar with the patients' needs, their likes and dislikes.

The patients spoken to had no concerns regarding the management of their medicines and advised that staff responded in a timely manner to any requests for pain relief or care. They were complimentary about the staff and management. One patient discussed some matters in relation to care and these were shared with the registered manager.

As part of the inspection, questionnaires were issued to patients, their relatives/representatives and staff. Ten questionnaires were completed and returned. The responses were recorded as 'very satisfied' or 'satisfied' with the management of medicines in the home.

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. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

In relation to the regional safeguarding procedures, staff confirmed they were familiar with these and were aware of when incidents must be considered as reportable to the adult safeguarding lead. Training had been provided and further training was planned. A safeguarding file was in place and included a policy, details of the names and contact numbers for the safeguarding lead and the safeguarding team. A specific flowchart was in place to report incidents.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents.

A variety of internal auditing systems were in place for medicines management. They included daily, weekly and monthly audits. An overarching audit was completed by management monthly or quarterly; and in addition audits were completed by the community pharmacist. A review of the internal audit records indicated that largely satisfactory outcomes had been achieved. Where areas for improvement had been identified, these were shared with staff in writing, to read, address and sign. These were also raised at supervision.

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.

The staff spoken to at the inspection were very positive about their work, the good working relationships between staff and the support provided by the staff team and the registered manager. They were very complimentary regarding the leadership in the home and advised that the registered manager was always available and willing to listen.

The recommendations made at the last medicines management inspection had been addressed. There was evidence that the QIP was monitored as part of managements' internal audit processes.

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

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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 provider from their responsibility for maintaining compliance with the regulations and standards.

The Regulation and Quality Improvement Authority

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