Unannounced Follow Up
Medicines Management Inspection Report
27 November 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 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 box below
Person in charge at the time of inspection: Staff Nurse Anca Murasen until 11.00 and Ms Lyndsay Esler thereafter	**Date manager registered:** Ms Lyndsay Esler (Registration Pending)
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 27 November 2018 from 10.40 to 13.45.

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.

Following an increase in the number of reported medicine related incidents, other information received by RQIA and the outcomes of a care inspection completed on 5 July 2018, a medicines management inspection was undertaken on 9 July 2018. At that inspection we identified that robust arrangements were not in place for medicines management. To ensure that the necessary improvements were made, it was decided that a medicines management inspection would be completed.

This inspection sought to determine if the improvements in relation to the management of medicines had been made and embedded into practice and if the service was delivering safe, effective and compassionate care and if the service was well led.

The following areas were examined during the inspection:

- medicine records
- medicines administration
- medicines storage
- care planning

It was evidenced that the areas identified for improvement had been addressed effectively. Management had reviewed the systems in place. Staff had received further training on the management of medicines, roles and responsibilities and accountability. The evidence seen during the inspection indicated that the management of medicines supported the delivery of safe, effective and compassionate care and that the service was well led. The improvements which had taken place were acknowledged. These must be sustained in order that staff continue to deliver safe and effective care.

Patients were complimentary regarding their experience in the home. They spoke positively about the staff and care provision and were noted to be comfortable in their surrounding 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	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Lyndsay Esler, 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.

4.2 Action/enforcement taken following the most recent care inspection

An enforcement monitoring care inspection was undertaken on 21 September 2018 to assess the level of compliance achieved in relation to a Failure to Comply (FTC) Notice. This notice, issued on 11 July 2018, was due to identified shortfalls noted in a care inspection on 5 July 2018, regarding the delivery of safe and effective care, specifically those patients requiring diabetic management or oxygen therapy. Compliance was achieved.

5.0 How we inspect

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

- recent inspection reports and returned Quality Improvement Plans (QIPs)
- recent correspondence regarding the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection

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

During the inspection we met with two patients, two registered nurses and the manager.

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

- medicines received
- personal medication records
- medicine administration records
- medicine audits
- care plans
- medicines storage temperatures

Areas for improvements identified at the last medicines management inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

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 21 September 2018

The most recent inspection of the home was an announced enforcement monitoring care inspection. There were no new areas for improvement made as a result of the inspection.

The completed QIP from the unannounced care inspection on 5 July 2018 was not validated at this inspection and will be reviewed by the care inspector at the next care inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 9 July 2018

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** First time	The registered person shall review the management of eye preparations as identified at the inspection and provide details of the findings and action taken.	**Met**
	Action taken as confirmed during the inspection: After the last medicines management inspection, we were advised that a full review of eye preparations had been completed. We examined medicine records, administration and storage in relation to several eye preparations; no further concerns were identified.	

Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time	The registered person shall ensure that records of the administration of external preparations are fully and accurately maintained.	**Met**
	Action taken as confirmed during the inspection: There was evidence of improvement in the record keeping for the administration of external preparations. A system had been developed and implemented to enable care staff to record administration. Although, these medicines were included in the weekly audit process, we noted that there were some omissions in the records; the manager confirmed that this had been identified in the most recent audit and that supervision with staff was to be completed. Given these assurances this area for improvement was assessed as met.	
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: An air-conditioning unit had been installed and was in use. Daily room temperatures were being recorded and these were maintained below 25^{o}C.	
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of Compliance**
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that all transcribing on medication administration records involves two staff and both staff sign the entry.	**Met**
	Action taken as confirmed during the inspection: There was evidence that two staff were involved in the transcribing of medicine details on medication administration records.	

Area for improvement 2 **Ref**: Standard 29 **Stated:** First time	The registered person shall review the process for the administration of medicines as detailed in the report.	**Met**
	Action taken as confirmed during the inspection: Medicines were administered by two registered nurses and the time of administration was accurately recorded. There was no evidence of any delays in the administration of medicines.	
Area for improvement 3 **Ref**: Standard 4 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: An improvement in the completion of care plans regarding medicines management was observed. A few care plans regarding distressed reactions were not in place and this was addressed before the end of the inspection.	
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that all medicines are clearly identifiable.	**Met**
	Action taken as confirmed during the inspection: All of the medicines examined were appropriately labelled. A new medicine system had been implemented in the last two weeks; seven day or 28 day blister packs were no longer in use.	
Area for improvement 5 **Ref**: Standard 28 **Stated:** First time	The registered person shall further develop the auditing processes for medicines management to ensure that they are effective.	**Met**
	Action taken as confirmed during the inspection: The manager advised of the daily, weekly and monthly auditing processes. The inspection outcomes indicated that various aspects of medicines management were regularly reviewed and addressed with staff as required.	

6.3 Inspection findings

Medicines records

We examined several patients' medicine records and evidenced a good standard of record keeping. There were safe systems in place to manage new medicines and medicine changes. Medicine records were legible and included the necessary information to direct the care of the patient; this included reminders for medicines which were prescribed at weekly intervals and alerts when more than one medicine containing paracetamol was prescribed. There was evidence that medicine records were included in the audit process.

Medicines administration

A range of medicines and medicine formulations were audited. The outcomes indicated that patients were being administered their medicines as prescribed. If a medicine was omitted the reason for the omission was recorded. The weekly audit process included a review of a sample of medicines, including thickening agents and external preparations. Following the introduction of the new medicine system, all boxed medicines were counted each day and a running stock balance maintained. No discrepancies were observed.

We spoke with two patients who advised that staff administered their medicines on time. They stated they had no pain and spoke positively about the care provided and the staff interactions with them.

Medicines storage

The treatment room had been refurbished and an air conditioning unit installed. Each patient's medicines were clearly segregated to identify the supply. Temperatures of medicine storage areas were monitored and recorded on a daily basis. All of the medicines examined were being stored appropriately. It was agreed that the refrigerator thermometer would be checked for accuracy, as some temperatures above +8^{o}C were noted; however, the medicines in the refrigerator were cool. The date of opening was recorded on limited shelf-medicines e.g. eye preparations and were within the in use date.

Care planning

A range of care plans relating to medicines management were examined. There was evidence that these were reviewed at least monthly. They included pain management, refusal of medicines, oxygen therapy, swallowing difficulty, antibiotics and infection, covert administration and distressed reactions.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the governance arrangements for medicines, the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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