The Regulation and Quality Improvement Authority

Inspection Report

19 May 2022

Drummaul House

Type of service: Nursing (NH)
Address: 41 New Street, Randalstown, BT41 3AF
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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: Hutchinson Homes Ltd **Responsible Individual:** Ms Naomi Carey	**Registered Manager:** Mrs Maria Margaret Bothwell **Date registered:** 01 April 2005
Person in charge at the time of inspection: Emma Espina – Senior nurse	**Number of registered places:** 43 This number includes a maximum of seven patients in category NH-DE. The home is also approved to provide care on a day basis only to 2 persons.
Categories of care: Nursing Home (NH) I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia	**Number of patients accommodated in the nursing home on the day of this inspection:** 35
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides both general nursing care and care for people living with dementia. The home is divided in two units over two floors. A downstairs unit provides care for up to seven people living with dementia. Patients have access to communal lounges, dining rooms and a garden space.	

2.0 Inspection summary

An unannounced inspection took place on 19 May 2022, from 10.15am to 2.15pm. The inspection 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. Progress with the area for improvement identified at the last inspection was also assessed.

Review of medicines management found that there were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed.

Three areas of improvement were identified in relation to medicine related records and the management of insulin. The area for improvement identified at the last inspection had been addressed.

Whilst areas for improvement were identified, it was concluded that overall, the patients were being administered their medicines as prescribed. RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the management team.

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 also 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 nursing staff including the senior nurse in charge. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

Staff spoken with told us that there was a good sense of teamwork in the home and 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 7 October 2021		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 12.13 **Stated:** First time	The registered person shall review the dining experience for patients to ensure: • The daily menu offers a choice of meal for patients.	**Met**
	Action taken as confirmed during the inspection: Review of the weekly menu evidenced two meal options were available for all patients at lunch and dinner time.	

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.

Paper based personal medication records were in place for each patient and these were stored in the medicines file. Electronic personal medication records were also available for inspection 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.

It was identified that the paper based records stored in the medicines file were not up to date with the most recent prescription and some were incomplete.

Discrepancies were observed between the paper based records and the electronic personal medication records. Staff in the home were referring to the paper based personal medication records during the medicines administration process. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. Discussions were held with the nurse in charge and it was emphasised that paper based personal medication records maintained in the medicines file should be fully complete and accurate and reflective of the accurate electronic records. An area for improvement was identified.

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 good 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 nurses 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 nurses 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 the management of distressed reactions was reviewed for three patients. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Nurses knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. The reason for and outcome of each administration was recorded on electronic medicine administration records.

The management of pain was reviewed. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. A care plan was not in place for one of two patients reviewed. The nurse in charge gave an assurance that this would be addressed following the inspection to ensure care plans for all patients prescribed pain relief are in place.

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 and nutritional supplements was reviewed for three patients. A speech and language assessment report and care plan was in place for each patient. Records of prescribing and administration which included the recommended consistency level were maintained.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

The management of insulin prescribed for patients to manager their diabetes was reviewed. Care plans were in place when patients required insulin and there was sufficient detail to direct staff if the patient's blood sugar was too high or low. In-use insulin pen devices were stored in the medicines refrigerator, however not all pens were individually labelled to denote ownership. The date of opening was not recorded on any of the in-use insulin pen devices. This is necessary to facilitate audit and disposal at expiry. An area for improvement was identified.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines 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 medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Temperatures of medicine storage areas were 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. Records were maintained and available for review.

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 record of the administration of medicines is recorded on electronic medicine administration records. A sample of the records reviewed identified a number of discrepancies in the recording of the administration of antibiotic and anticoagulant medicines. Audits completed by the inspector identified these medicines had been administered as prescribed but had been recorded incorrectly on the medicine administration record. Accurate recording of the administration of medicines is necessary to evidence medicines are administered as prescribed. An area for improvement was identified.

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. The nurse in charge was reminded that staff should consistently record the name of the hospital/community pharmacy controlled drugs are received from in the controlled drug record book.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. Weekly medicine administration audits are completed as well as a monthly overview audit which encompasses all aspects of medicines management. The date of opening was recorded on the majority of 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 medicines were being administered as prescribed.

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. Recent training on the newly implemented electronic medicines record system had been provided for all nurses responsible for the management of medicines. 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

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	1	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Emma Espina, senior nurse in charge, as part of the inspection process. The timescales for completion commence 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 13 (4) **Stated:** First time **To be completed by:** Ongoing from the date of inspection (19 May 2022)	The registered person shall ensure that personal medication records are fully and accurately completed and are reflective of the patient's currently prescribed medicines. Ref: 5.2.1 **Response by registered person detailing the actions taken:** All registered Nurses have been advised to continue to ensure that all the medication records are accurately completed. An electronic recording and administration is also now in place and is assisting with the prompting, updating and mangement process.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 28 **Stated:** First time **To be completed by:** Ongoing from the date of the inspection (19 May 2022)	The registered person shall review the management of insulin to ensure in-use insulin pen devices are individually labelled to denote ownership and the date of opening is recorded to facilitate audit and disposal at expiry. Ref: 5.2.1 **Response by registered person detailing the actions taken:** All insulin pens are labelled to ensure ownership, staff are reminded to write the date and time of opening.
Area for improvement 2 **Ref**: Standard 29 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (19 May 2022)	The registered person shall ensure accurate records of the administration of medicines are maintained. Ref: 5.2.3 **Response by registered person detailing the actions taken:** Staff are reminded to adhere to NMC standards when administrating medications and are continuing to follow.

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