Inspection Report
25 March 2021

Drapersfield House

Type of Service: Nursing Home
Address: 19 Drapersfield Road, Cookstown, BT80 8RS
Tel No: 028 8676 4868
Inspectors: Judith Taylor and Philip Lowry

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 this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a nursing home which is registered to provide care for up to 45 patients.

2.0 Service details

Organisation/Registered Provider: Drapersfield Ltd **Responsible Individual** Mrs Jill Canavan	**Registered Manager and date registered:** Mrs Margaret Kolbohm 16 June 2016
Person in charge at the time of inspection: Ms Ailish Devlin, Clinical Lead Nurse	**Number of registered places:** 45 There shall be a maximum of one named patient in category NH-LD(E) and a maximum of one named patient in category NH-MP(E). There shall be a maximum of two named residents receiving residential care in category RC-I.
Categories of care: Nursing (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	**Total number of patients in the nursing home on the day of this inspection:** 38

3.0 Inspection focus

This inspection was undertaken by two pharmacist inspectors on 25 March 2021 from 10.20 to 16.20.

This inspection focused on medicines management within the home and also assessed progress with any areas for improvement identified since the last care and medicines management inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- reviewed documents to confirm that appropriate records were kept

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drug records
- care plans related to medicines management
- governance and audit
- staff training and competency records
- medicine storage temperatures
- RQIA registration certificate
- admission information for new patients
- governance and audit
- management of medication incidents

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	4*	5*

*The total number of areas for improvement includes three that have been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Ailsih Devlin, Clinical Lead Nurse, 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.

5.0 What has this home done to meet any areas for improvement identified at the last medicines management inspection (25 February 2019) and last care inspection (12 January 2021)

Areas for improvement from the last medicines management inspection		
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:** Second time	The registered person shall ensure that when medicines are administered on a "when required" basis for the management of distressed reactions, the reason for and outcome of the administration is recorded.	**Met**
	Action taken as confirmed during the inspection: A separate chart was in place which detailed the reason for and outcome of administration.	

Areas for improvement from the last care inspection		
Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 15 (1) (e) **Stated:** First time	The registered person shall ensure that at all times admissions to the home are in accordance with the categories and conditions of care for which the home is registered unless discussed with and approved by RQIA.	**Met**
	Action taken as confirmed during the inspection: We discussed the categories and conditions of care for the current patients and also new patients admitted to the home. These matched with the details of our register.	

Area for improvement 2 **Ref:** Regulation 27 (4) (b) **Stated:** First time	The registered person shall take adequate precautions against the risk of fire. With specific reference to ensuring that: • The practice of propping open the identified bedroom door is reviewed and appropriate measures are implemented in accordance with fire safety regulations.	**Carried forward for review at next inspection**
	Action taken as confirmed during the inspection: To reduce the footfall around the home, the inspectors remained in the treatment room and therefore this was not examined and is carried forward for review at the next inspection.	
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 6 **Stated:** First time	The registered person shall ensure that patients' personal care and grooming needs are met. Care records should reflect specific measures on how to maintain patients' personal care and clearly record the type of intervention provided.	**Carried forward for review at next inspection**
	Action taken as confirmed during the inspection: To reduce the footfall around the home, the inspectors remained in the treatment room and therefore this was not examined and is carried forward for review at the next inspection.	
Area for improvement 2 **Ref**: Standard 23.2 **Stated:** First time	The registered person shall ensure that where a wound has been assessed as requiring treatment, a care plan is implemented to include the dressing type and frequency of dressing renewal and is updated when necessary to reflect any changes.	**Carried forward for review at next inspection**
	Action taken as confirmed during the inspection: To reduce the footfall around the home, the inspectors remained in the treatment room and therefore this was not examined and is carried forward for review at the next inspection.	

6.0 What people told us about this home

The inspectors did not met with any patients at the time of the inspection, as most of the inspection was kept to limited areas, to reduce footfall around the home.

We met with one care staff, two nurses and the clinical lead nurse. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff expressed satisfaction with how the home was managed. The staff were complimentary about the home, the working relationships, team working, ethos of the home and the management team. They also said that they had the appropriate training to look after patients and meet their needs. It was evident from discussion that the staff were knowledgeable about patients' medicines and their prescribed care.

Feedback methods included a staff poster and paper questionnaires which were provided to the person in charge for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, questionnaires were received from six patients, two relatives and six members of staff. Comments and responses stated that they were very satisfied/satisfied with the care provided.

7.0 Inspection Findings

7.1 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 will 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 local GP and medicines were dispensed by the community pharmacist.

A sample of patients' personal medication records was reviewed. 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 to patients as prescribed; and because they may be used by other healthcare professionals, for example, at medication reviews and/or hospital appointments. Overall, these were well maintained. In line with best practice, a second member of staff had checked and signed these records when they were written and updated, to ensure that they were accurate.

However, it was noted that obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the patient.

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. A few of these needed archived to ensure that only the current letter was held in the folder.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets, self-administration etc.

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 staff 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 staff 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. We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions. 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. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available in the medicines file. Records of administration including the reason for and outcome of administration were maintained.

Pain management was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Pain assessments were completed at regular intervals and care plans were maintained.

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. There was evidence that speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Medicines, such as warfarin and injectable medicines, including insulin are considered high risk medicines; therefore detailed care plans and written confirmation of medicine dosage regimes must be in place. There was evidence that care plans for high risk medicines were in place. The good practice of maintaining separate administration charts signed by two staff was acknowledged. However, written confirmation of the most recent warfarin regime was not in place. Obsolete regimes remained in the current folder and prescribed warfarin doses were communicated to one member of staff by telephone. Any telephoned instructions should be heard by two staff to ensure both have understood the dose. This was discussed and an area for improvement was identified.

7.2 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.

Staff advised that they had a good relationship with the community pharmacist and that medicines are supplied in a timely manner. The records examined showed that most medicines were available for administration when patients required them. One patient's record showed that three doses of a medicine had been missed as there was no supply available. This was reviewed and it was found that the medicine was held in stock, but this had not been noted and the missed doses had not been reported to management. See Section 7.6.

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. However, expired medicines and excess supplies of a number of medicines were observed. Systems should be in place to monitor expiry dates to ensure these are removed from stock in a timely manner; and medicines should only be ordered as needed. An area for improvement was identified. It was agreed that the monthly ordering process would be reviewed and followed up with the prescriber as necessary.

Temperatures of medicines storage areas were monitored and recorded on a daily basis to ensure medicines were stored correctly.

Discontinued medicines including controlled drugs were safely disposed of and records maintained.

7.3 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 sample of medicine administration records were examined. Some of these had been fully and accurately completed. These were printed or handwritten. When handwriting these records, two staff should be involved and both should initial the entry to ensure accuracy. Reminder systems were in place to assist staff in administering medications outside of the usual medicine round times or medicines which were prescribed on a weekly, fortnightly or three monthly basis. This is an example of good practice. However, one patient missed their dose of a weekly pain relieving patch; this had not been recognised or reported to the manager. Management investigated this immediately after the inspection and forwarded details to RQIA including the corrective action taken. See also Section 7.1. Other records indicated that an eye preparation had not been administered as prescribed; and one discontinued medicine(tablet) was being administered. This was discussed and staff had continued to sign the record but had not actually administered the tablet. Medicine administration records should be checked against the personal medication records at the beginning of each medicine cycle to ensure that they

correlate and staff should also be referring to the personal medication record at each medicine round. Two areas for improvement were 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 were recorded in a controlled drug record book. Staff were reminded that balances should be brought to zero when the complete supply of the controlled drug has been disposed of or transferred; and that staff should not score off the entire page when a controlled drug is no longer prescribed.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice. The audits we completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a small number of medicines. A review of the management and staff audits indicated that the issues raised at this inspection were not being identified. The need for a robust audit system which covers all aspects of medicines is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff. An area for improvement was identified.

7.4 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.

The admission process for patients new to the home or returning to the home after receiving hospital care was reviewed. Staff advised that robust arrangements were in place to ensure that they were provided with written confirmation of the patient's medicine regime at or prior to admission and details updated on the patient's records. Systems were in place to follow up on any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

7.5 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. An effective auditing system helps staff to identify medicine related incidents.

Review of the medicine related incidents which had been reported to RQIA since the last inspection, indicated that management and staff were familiar with the type of incidents that should be reported and how they should be managed. However, as we identified errors in administration and recording, this indicates that the auditing system is not robust and hence incidents may not be identified. See Section 7.3.

7.6 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 staff are competent in managing medicines and that staff are supported.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

8.0 Evaluation of Inspection

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

The outcome of this inspection concluded that with the exception of a small number of medicines, the patients were being administered their medicines as prescribed by their GP. However, areas for improvement were identified to ensure that robust arrangements are in place for medicines management. These are detailed in the QIP which also includes three areas which have been carried forward for review at the next inspection.

We would like to thank the patients, their representatives and staff for their assistance with the inspection.

9.0 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 Ms Ailish Devlin, Clincal Lead Nurse, 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.

9.1 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.

9.2 Actions to be taken by the home

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 the 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:** Immediate and ongoing	The registered person shall ensure that updates to warfarin dosage regimes are received in writing on each occasion and in a timely manner. Ref: 7.1
	Response by registered person detailing the actions taken: Written confirmation obtained with warfarin dosage regimes are in place and received in a timely manner. Same monitored supervisions carried out with staff re above.
Area for improvement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall review the administration of medicines process to ensure records are accurately maintained. Ref: 7.3
	Response by registered person detailing the actions taken: All medications reviewed and maintained accurately, same is monitored and audited.
Area for improvement 3 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall develop a robust auditing process which covers all aspects of medicines management. Ref: 7.3 and 7.6
	Response by registered person detailing the actions taken: Audit process had been in place and has been further developed to ensure robust management of medicines.
Area for improvement 4 **Ref:** Regulation 27(4) (b) **Stated:** First time **To be completed by:** With immediate effect (from 12 January 2021)	The registered person shall take adequate precautions against the risk of fire. With specific reference to ensuring that: • The practice of propping open the identified bedroom door is reviewed and appropriate measures are implemented in accordance with fire safety regulations.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and is carried forward to the next inspection. Ref: 5.0

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 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that all obsolete records are discontinued and securely archived. Ref: 7.1
	Response by registered person detailing the actions taken: All absolute records have been removed and archived. Supervision carried out re same.
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall review the stock control of medicines to ensure that expired medicines are removed from stock and medicines are only ordered as needed. Ref: 7.2
	Response by registered person detailing the actions taken: Medicines reviewed all expired medications removed and medicines are only ordered as needed. Supervision carried out.
Area for improvement 3 **Ref**: Standard 29 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that all handwritten entries on medication administration records involve two trained staff to check that the information is accurate. Ref: 7.3
	Response by registered person detailing the actions taken: 1. Two signatures are obtained for all handwritten entries in medication administration records. Same monitored and supervision carried out re same.
Area for improvement 4 **Ref**: Standard 6 **Stated:** First time **To be completed by:** With immediate effect (from 12 January 2021)	The registered person shall ensure that patients' personal care and grooming needs are met. Care records should reflect specific measures on how to maintain patients' personal care and clearly record the type of intervention provided.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and is carried forward to the next inspection. Ref: 5.0
Area for improvement 5 **Ref**: Standard 23.2 **Stated:** First time **To be completed by:** With immediate effect (from 12 January 2021)	The registered person shall ensure that where a wound has been assessed as requiring treatment, a care plan is implemented to include the dressing type and frequency of dressing renewal and is updated when necessary to reflect any changes.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and is carried forward to the next inspection. Ref: 5.0

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

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