# Unannounced Inspection Report
# 10 September 2020

# Moneymore

**Type of Service: Nursing Home**
**Address: Cookstown Road, Moneymore, Magherafelt BT45 7QF**
**Tel no: 028 8674 8118**
**Inspectors: Mandy Ellis and 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 from their responsibility for maintaining compliance with legislation, standards and best practice.

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 and the DHSSPS Care Standards for Nursing Homes 2015.

## 1.0 What we look for


## 2.0 Profile of service

This is a nursing home registered to provide nursing care for up to 41 persons.

## 3.0 Service details

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|---|---|
| **Organisation/Registered Provider:**<br>Four Seasons Health Care<br><br>**Responsible Individual:**<br>Maureen Claire Royston | **Registered Manager and date registered:**<br>Shauna Rooney<br>26 March 2020 |
| **Person in charge at the time of inspection:**<br>Shauna Rooney | **Number of registered places:**<br>41<br><br>A maximum of one patient in category NH-PH. |
| **Categories of care:**<br>Nursing Home (NH)<br>I – Old age not falling within any other category<br>PH – Physical disability other than sensory impairment | **Number of patients accommodated in the nursing home on the day of this inspection:**<br>30 |

## 4.0 Inspection summary

An unannounced inspection was undertaken by a care and pharmacist inspector on 10 September 2020 from 10.00 to 17.15 hours.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DOH) directed RQIA to prioritise inspections to homes on the basis of risk.

The following areas were examined during the inspection:

- staffing arrangements
- Personal Protective Equipment (PPE)
- Infection Prevention and Control (IPC)
- environment
- care delivery
- medicines management
- governance and management arrangements

The findings of this report will provide Moneymore Care 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** | 2* | 4* |

*The total number of areas for improvement includes one area under the regulations which has not been met and is stated for the third and final time; and one area under the care standards which has been partially met and is stated for the third and final time.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Shauna Rooney, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

## 5.0 How we inspect

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

- notifiable events since the last care and medicines management inspections
- the registration status of the home
- written and verbal communication received since the last care and medicines management inspections
- the returned QIP from the last care inspection
- the last care and medicines management inspection reports

During the inspection we met with five patients and eight staff. Questionnaires were also left in the home to obtain feedback from patients and their relatives/ representatives. Ten questionnaires were left for distribution. A poster was also displayed for staff inviting them to provide feedback to RQIA on-line.

We provided the manager with 'Tell us cards' which were then placed in a prominent position to allow patients and their relatives/representatives, who were not present on the day of inspection, the opportunity to give feedback to RQIA regarding the quality of service provision.

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

- the duty rota from 31 August 2020 to 13 September 2020
- the home's registration certificate
- three patients' care records
- eight patients' supplementary care charts
- two staff recruitment files
- a sample of governance audits/records
- a sample of monthly monitoring reports
- personal medication records
- medicine administration records
- medicine receipt and disposal records
- controlled drugs records
- the management of nutrition and medicines via the enteral route

- care plans related to medicines management:
  - four patients requiring a modified diet
  - three patients prescribed medicines for distressed reactions
  - four patients prescribed medicines for pain
  - two patients prescribed injectable medicines
- staff training and competency in medicines management
- medicine storage temperatures

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

## 6.0 The inspection

## 6.1 Review of areas for improvement from previous inspection(s)

The last medicines management inspection of the home was undertaken on 7 September 2017. No areas for improvement were identified at that inspection.

The most recent inspection of the home was an unannounced care inspection undertaken on 30 October 2019.

| **Areas for improvement from the last care inspection** | | |
|---|---|---|
| **Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005** | | **Validation of compliance** |
| **Area for improvement 1**<br><br>**Ref**: Regulation 13 (1) (a)<br><br>**Stated:** Second time | The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals.<br><br>Specific reference to recording charts and daily records:<br><br>• Action taken should be documented within daily records when set fluid targets have not been maintained.<br>• Where a patient has been repositioned the frequency should reflect the current care plan and state the intervention on each repositioning. | **Not met** |

| | | |
|---|---|---|
| | **Action taken as confirmed during the inspection**:<br>A review of care records did not evidence actions taken when fluid targets had not been achieved. Repositioning records reviewed evidenced deficits in the recording of the prescribed care in the patient's care plan. This is further discussed in section 6.2.4.<br><br>**This area for improvement will be stated for the third and final time.** | |
| **Action required to ensure compliance with The Care Standards for Nursing Homes (2015)** | | **Validation of compliance** |
| **Area for improvement 1**<br><br>**Ref**: Standard 14.26<br><br>**Stated:** Second time | The registered person shall ensure that an inventory of property belonging to each patient is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff. | **Partially met** |
| | **Action taken as confirmed during the inspection**:<br>A review of records evidenced that an inventory record of patient property is now in place; but of the records reviewed, we identified these were not always accurate or up to date.<br><br>**This area for improvement will be stated for the third and final time.** | |
| **Area for improvement 2**<br><br>**Ref**: Standard 2.8<br><br>**Stated:** Second time | The registered person shall ensure that any changes to the individual agreement are agreed in writing by the patient or their representative. The individual agreement is updated to reflect any increases in charges payable. Where the patient or their representative is unable to or chooses not to sign the revised agreement, this is recorded. | **Met** |
| | **Action taken as confirmed during the inspection**:<br>A review of records confirmed the individual agreements were appropriately signed and up to date. | |

## 6.2 Inspection findings

### 6.2.1 Staffing arrangements

On arrival to the home we were greeted by staff who were friendly and welcoming. There was a relaxed and pleasant atmosphere throughout the home. We were advised that staff had a temperature and symptom check upon arrival to work and upon finishing their shift; a record of this was maintained. It was encouraging to note that inspectors were also required to undergo a temperature and symptom check upon arrival to the home.

On the day of the inspection we observed that staffing levels were satisfactory and patients' needs were being met in a prompt and timely manner. The manager told us that planned daily staffing levels were subject to regular review to ensure that the assessed needs of patients were met. We reviewed the duty rotas for the period from 31 August 2020 to 13 September 2020. The duty rotas reviewed reflected that the planned daily staffing levels were adhered to.

Staff spoken with told us that there was a good sense of teamwork in the home and that they enjoyed coming to work. They expressed satisfaction with how the home was managed and also said that they had the appropriate training to look after patients and meet their needs. It was acknowledged that some staff had worked in the home for several years and were very familiar with their roles and responsibilities within the organisation and the home.

Two staff members commented on the busyness of the morning shift and felt the home would benefit from an additional staff member particularly at this time; these comments were shared with the manager for her consideration.

Comments made by staff included:
- "I love my job."
- "Things are ok."
- "We are like a wee community in here."
- "This is home from home for the residents."
- "I love my work."

### 6.2.2 Personal Protective Equipment

Staff were observed to use PPE appropriately and were observed to carry out hand hygiene at appropriate times during our visit. PPE stations were well stocked throughout the home and the home had an adequate supply of PPE.

### 6.2.3 Infection Prevention and Control/Environment

We reviewed the home's environment undertaking observations of a sample of bedrooms, bathrooms, lounges, dining rooms, sluices and storage areas. The home was fresh smelling throughout. The patients' bedrooms which were viewed, were clean, warm and had been personalised with items that were meaningful to individual patients.

However, hoists were seen to be stored in corridors when not in use and a patient's chair was seen obstructing a fire exit; these observations were discussed with the manager and the items were moved during the inspection. In the event of an emergency these pieces of equipment would be a potential obstruction and could prevent clear exit from the building. This was identified as an area for improvement in order to comply with the regulations.

### 6.2.4 Care delivery

We observed that patients looked well cared for and were content and settled in their surroundings. There was a friendly and relaxed atmosphere in the home. We observed the patients enjoying each other's company in the lounges and the patients we met with spoke very highly of the activity coordinator for the home. We also met with the activity coordinator who showed us the activity records and the planned activities for the week; her enthusiasm and energy for her role was very evident.

We observed the serving of lunch in the dining room and found this to be a pleasant and unhurried experience for the patients. The dining room was clean and tidy and had recently been redecorated. The daily menu was displayed; we observed that the food provided was well presented and smelled appetising; and the staff were helpful and attentive. Due to efforts to adhere to social distancing, there was a limited number of patients in the dining room; but we noted that the remainder of the patients were served their lunch in the day room or their bedrooms.

The patients we met with spoke positively about their care in the home, how well they were looked after by the staff and how they enjoyed the food. They told us:

- "The nurses and the kitchen staff are very good."
- "Things are good here."
- "I feel safe here."
- "The food is good."
- "It's ok."
- "Things are dead on."

We reviewed the standard of record keeping in relation to care plans and supplementary care records. Care plans and risk assessments were in place to direct the care required and reflected the assessed needs of the patients. These were reviewed regularly.

However, we identified shortfalls in the completion of the following records and these were discussed with the manager:

- the level of detail in the patient's care plan review was not meaningful
- details of care delivery were not fully recorded by night staff
- the completion of repositioning records showed that the prescribed repositioning arrangements for the patient were not being adhered to
- there was poor quality of documentation in one patient's daily progress records
- records were incomplete as the time of the written update was missing on two occasions
- there was no evidence of a robust process to ensure the patient's prescribed fluid had been achieved every 24 hours.

Due to these findings an area for improvement was identified in order to comply with the care standards and the area for improvement identified which had not been fully addressed (see section 6.1) has been stated for a third and final time.

### 6.2.5 Medicines management

#### 6.2.5.1 Personal medication records and associated care plans

Patients in care 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, medical consultant or the pharmacist.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place 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, medication reviews or hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with safe practice, a second member of staff had checked and signed the personal medication records when they were written and updated to check that they were accurate. 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 best practice.

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, injectable medicines, modified diets and self-administration.

Patients will sometimes get distressed and may be prescribed 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. The reason for and outcome of administration were recorded.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Pain management care plans and pain assessments were maintained and detailed the medicines prescribed.

In relation to the management of injectable medicines, we observed that that relevant care plans were in place and records were well 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.

We reviewed the management of thickening agents. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level of fluids were maintained.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral tube. We reviewed the management of medicines and nutrition via the enteral route. Systems were in place to ensure that an up to date regime was in place and records of nutrition and fluids administered were maintained. From these records it was evident that the daily target volume of liquid prescribed had been achieved. Staff were reminded to total the 24 hour intake each day. The manager assured us that this would be reviewed with immediate effect.

#### 6.2.5.2 Medicine storage and record keeping

Medicine 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 usually supplied in a timely manner. There was evidence that if there were low stock levels of medicine or the medicine had not been supplied, this was followed up in a timely manner.

The medicines storage areas, including the medicine trolleys, controlled drug cabinet and medicines refrigerator were observed to be securely locked to prevent any unauthorised access. They were clean, tidy and well organised so that medicines belonging to each patient could be easily located. However, we noted some expired medicines, unlabelled medicines and two antibiotics which were no longer required. These were removed for disposal. It was agreed that this would be addressed as part of the monthly stock control.

We reviewed the disposal arrangements for medicines. Discontinued medicines were uplifted by a clinical waste company. A record of all discontinued medicines was maintained. This record provides evidence that the home is no longer responsible for the medicines and also facilitates the audit process. To ensure robust systems are in place for disposal, two staff should be involved in the process and both staff should sign the disposal record. Where there are controlled drugs awaiting disposal, those in Schedules 2, 3 and 4 (Part 1) must be destroyed before they are put in the waste disposal bin, and this should be noted on the disposal records. These records rarely included a staff signature and there was no evidence that all controlled drugs in Schedule 3 and 4 (Part 1) were destroyed. The disposal of medicines was identified as an area for improvement in order to comply with the care standards.

### 6.2.5.3 Administration of medicines

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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. With the exception of prescribed topical medicines, for example, creams, these records were found to have been fully and accurately completed. Handwritten entries were routinely signed by two nurses to ensure accuracy. This is safe practice. We acknowledged the organised filing systems in place for obsolete/completed records, which were readily available to view.

In relation to topical medicines, the manager advised that improvement needed in this area had been identified through an audit at the end of last month. We observed similar findings following examination of current records at the inspection and could not evidence that all prescribed topical medicines had been administered. We discussed the current process and gave advice. This was identified as an area for improvement in order to comply with the care standards.

Management and staff audited medicine administration on a regular basis within the home. This is necessary to ensure that robust systems are in place for the safe management of medicines and also to ensure that the patient has been administered their medicines. The date of opening was recorded on all medicines so that they could be easily audited. Staff had also recorded daily stock balances for the majority of inhaled and oral medicines, and the stock balance of medicines which were carried over for use in the next medicine cycle. These are areas of good practice and enable staff to identify if there are any errors. The majority of audits completed during this inspection showed that medicines had been given as prescribed. Some minor discrepancies were identified and highlighted for attention.

### 6.2.5.4 Management of medicines on admission/re-admission to the home

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.

We discussed the admission process for patients new to the home or returning to the home after receiving hospital care. Staff advised that robust arrangements were in place to ensure that they were provided with written confirmation of the patient's medicine regime and this was also shared the community pharmacist. We evidenced this in one patient's records. The hospital discharge letter had been received and a copy had been forwarded to the patient's GP. The patients' personal medication record had been written to reflect the current medicine regime.

### 6.2.5.5 Medicine related incidents

Occasionally medicine 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.

The audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported.

We discussed the medicine related incidents which had been reported to RQIA since the last inspection. These had been managed appropriately. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

### 6.2.5.6 Medicines management training

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. Records of staff training in relation to medicines management were maintained.

### 6.2.6 Governance and management arrangements

Following review of a sample of governance audits, it was evident that the manager maintained a good level of oversight in the home. This included the development of action plans to address identified deficits. Monthly monitoring reports were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

In relation to notifiable events, robust systems were in place to ensure that these were readily identified, and to ensure they were reported to RQIA or other relevant bodies appropriately.

Two recruitment files for newly appointed staff were reviewed. We noted that the appropriate pre-employment checks had been completed prior to the staff member commencing employment.

There was a system in place to monitor the registration status of nursing and care staff with their appropriate regulatory body on a regular basis. The records reviewed were up to date.

### Areas of good practice

There were examples of good practice identified in relation to the activities programme; staff interaction with the patients; use and availability of PPE; administration of the majority of medicines and medicines training.

**Areas for improvement**

Four new areas for improvement were identified in relation to fire safety, care documentation, the disposal of controlled drugs and the administration of topical medicines.

| | Regulations | Standards |
|---|---|---|
| **Total number of areas for improvement** | 1 | 3 |

## 6.3 Conclusion

On the day of the inspection we observed that patients appeared comfortable, and that staff treated them with kindness and compassion. The staff were timely in responding to the patient's individual needs. PPE was appropriately worn by staff. In relation to medicines, we can conclude that overall, the patients were being administered their medicines as prescribed.

Four new areas for improvement were identified as outlined in this report.

We would like to thank the patients and staff for their assistance throughout the inspection

## 7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Shauna Rooney, 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 Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (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

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|---|---|
| **Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005** | |
| **Area for improvement 1**<br><br>**Ref**: Regulation 13 (1) (a)<br><br>**Stated:** Third and final time<br><br>**To be completed by:**<br>With immediate effect | The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals.<br><br>Specific reference to recording charts and daily records:<br><br>• Action taken should be documented within daily records when set fluid targets have not been maintained<br>• Where a patient has been repositioned the frequency should reflect the current care plan and state the intervention on each repositioning.<br><br>Ref: 6.1 and 6.2.4 |
| | **Response by registered person detailing the actions taken:**<br>Daily fluid totals are recorded in progress notes and added to the shift report, when fluid targets have not been met the action taken is recorded in residents notes.<br>A full review of all residents repositioning needs has taken place to ensure that the appropriate interventions are in place. Care plans and repositioning regimes have been updated to reflect residents current needs.<br>Both these areas are monitored by way of regular care plan audits. |
| **Area for improvement 2**<br><br>**Ref:** Regulation 27(4)(c)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With immediate effect | The registered person shall ensure that all fire exits and corridors are kept clear and unobstructed at all times.<br><br>Ref: 6.2.3 |
| | **Response by registered person detailing the actions taken:**<br>Fire exits and corridors are monitored via daily walkabout audits. Fire exit obstructions and corridor obstructions and the potential implications are discussed at flash meetings. |
| **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**<br><br>**Ref**: Standard 14.26<br><br>**Stated:** Third and final time<br><br>**To be completed by:** | The registered person shall ensure that an inventory of property belonging to each patient is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.<br><br>Ref: 6.1 |
| | **Response by registered person detailing the actions taken:** |

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| 10 October 2020 | The appropriate inventory of property recording document is now in place. Quarterly records of valuables are maintained which are signed and countersigned by a senior member of staff, these are reviewed every three months. |

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|---|---|
| **Area for improvement 2**<br><br>**Ref**: Standard 4.8 & 4.9<br><br>**Stated:** First time<br><br>**To be completed by:**<br>10 October 2020 | The registered person shall ensure the following with regard to patients care records:<br>• the daily care records clearly evidence the care delivered to patients by all care staff<br>• the time of entry should be clearly recorded on the daily progress notes<br>• patient care plans and risk assessments should be meaningfully reviewed.<br><br>Ref: 6.2.4 |
| | **Response by registered person detailing the actions taken:**<br>Daily care recording has been discussed via staff meetings and supervisions and is monitored via daily walkabouts.<br>Daily progress notes, care plans and risk assessments are reviewed via care file audits. |
| **Area for improvement 3**<br><br>**Ref**: Standard 28<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate and ongoing | The registered person shall make the necessary arrangements to ensure that disposal of medicines records are fully maintained; and clearly indicate that all controlled drugs in Schedules 3 and 4 (Part 1) have been denatured prior to disposal, by two trained staff.<br><br>Ref: 6.2.5.2 |
| | **Response by registered person detailing the actions taken:**<br>A new drug updated destruction book has now been implemented which includes an area for a second staff member to countersign all drugs destroyed. |
| **Area for improvement 4**<br><br>**Ref**: Standard 29<br><br>**Stated:** First time<br><br>**To be completed by:**<br>Immediate and ongoing | The registered person shall review the management of topical medicines to ensure that medicine records are fully and accurately completed.<br><br>Ref: 6.2.5.3 |
| | **Response by registered person detailing the actions taken:**<br>Topical medications have been reviewed and new Topical Medication administration recording sheets are being implemented at the beginning of each medicine cycle. Completion of topical administration has been discussed via supervision and is monitored via medication audits. |

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

The Regulation and Quality Improvement Authority

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