The Regulation and Quality Improvement Authority

Inspection Report

29 April 2021

Hawthorn Lodge

Type of Service: Residential Care Home
Address: 277 Killaughy Road, Ballyhay,
Donaghadee, BT21 0ND
Tel no: 028 9188 3009

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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Hawthorn Lodge **Responsible Individual:** Ms Isabelle Bustard	**Registered Manager:** Ms Isabelle Bustard **Date registered:** 1 April 2005
Person in charge at the time of inspection: Ms Isabelle Bustard	**Number of registered places:** 14
Categories of care: Residential Care (RC): I - Old age not falling within any other category DE - Dementia MP(E) - Mental disorder excluding learning disability or dementia - over 65 years LD - Learning Disability LD(E) - Learning disability - over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 11
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 14 residents.	

2.0 Inspection summary

An unannounced inspection took place on 29 April 2021, from 09.40 am to 12.40 pm. The inspection was completed by a pharmacist inspector.

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

Based on the inspection findings and discussions held we 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 manager in relation to the management of medicines. Two areas for improvement were identified in relation to record keeping.

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 the previous inspections findings, registration information, and any other written or verbal information received.

During the inspection, the inspector:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- 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
- medicine receipt and disposal
- controlled drug records
- care plans related to medicines management
- governance and audit
- staff training and competency
- medicine storage temperatures
- RQIA registration certificate

4.0 What people told us about the service

Staff were warm and friendly and it was evident from their interactions that they knew the residents well. They were wearing face masks and other personal protective equipment (PPE) as needed.

Staff spoken to expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after residents and meet their needs.

In order to reduce the footfall throughout the home, the inspector did not meet with any residents during the inspection. However, feedback methods included a staff poster and paper questionnaires which were provided to the manager for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes.

No questionnaires were returned within the designated timescale after the inspection.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last medicines management inspection and last care inspection?

Areas for improvement from the last pharmacy inspection on 20 March 2018		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 32 **Stated:** First time	The registered person shall ensure that the maximum and minimum refrigerator temperature is monitored daily and is maintained within the required range of 2°C and 8°C. **Action taken as confirmed during the inspection**: The manager provided records to evidence that the maximum and minimum temperature of the medicine refrigerator was monitored daily and was maintained within the required range of 2°C and 8°C.	**Met**
Areas for improvement from the last care inspection on 14 January 2021		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 35 **Stated:** First time	The registered person shall ensure that all pull cords throughout the home are fitted with washable covers in order to adhere to infection prevention and control best practice. **Action taken as confirmed during the inspection**: The pull cords throughout the home were fitted with washable covers in order to adhere to infection prevention and control best practice.	**Met**

5.2 Inspection outcome

5.2.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in care homes should be registered with a general medical practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times the residents' 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.

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

Personal medication records were in place for each resident. 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 e.g. medication reviews, hospital appointments.

Several personal medication records were incomplete. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. Also, it was not routine practice for two staff to perform an accuracy check and sign handwritten entries on the personal medication records and medicine administration records (MARs). Two areas for improvement were identified.

Copies of residents' 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.

All residents 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.

Residents 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 resident's distress and if the prescribed medicine is effective for the resident.

The management of medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident'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. These medicines were rarely used.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required.

A care plan and risk assessment was in place when a resident self-administers medication.

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 resident'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 residents required them. Staff advised that medicines were supplied in a timely manner.

The medicines storage area was securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located. A medicine refrigerator and controlled drugs cabinet were available for use as needed. The medicine refrigerator did not have a lock fitted; however, this was rectified during the inspection. The need to ensure this refrigerator is kept locked was emphasised.

Discontinued medicines were returned to the community pharmacy for disposal and records maintained.

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 residents 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 MARs or occasionally handwritten MARs, when medicines are administered to a resident. A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. The completed records were filed once completed.

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 appropriately recorded in a controlled drug record book. Handover stock checks were routinely completed by staff.

Management and staff audited medicine administration on a regular basis within the home. The date of opening was recorded on medicines so that they could be easily audited. This is good practice. The need to develop the auditing process to closely monitor the accuracy of the personal medication records and MARs was discussed with the manager.

The audits completed during this inspection showed that medicines had been given as prescribed.

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.

There had been no recent admissions to the home. The management of medicines for a resident who had a hospital stay and was discharged back to this home was reviewed. A hospital discharge letter had been received and a copy had been forwarded to the resident's GP. The resident's personal medication record had been updated to reflect medication changes which had been initiated during the hospital stay. However, the handwritten entries on the personal medication record and MARs had not been reviewed and signed by two staff (see section 5.2.1). Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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.

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.

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 residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that they are supported.

Staff had received a structured induction which included medicines management when this forms part of their role. Three new staff members were in the process of receiving medicines management induction training. 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 available for inspection.

6.0 Conclusion

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

The outcome of this inspection concluded that, whilst two areas for improvement were identified in relation to record keeping, the residents were being administered their medicines as prescribed.

The areas for improvement identified at the last care inspection and last medicines management inspection had been addressed.

Based on the inspection findings and discussions held, we 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 manager/management team.

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

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Residential Care Homes Regulations (Northern Ireland) 2005 and the Residential Care Homes Minimum Standards (2011).

	Regulations	Standards
Total number of Areas for Improvement	1	1

Areas for improvement and details of the Quality Improvement Plan were discussed Ms Isabelle Bustard, Registered Manager, 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 Residential Care Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13(4) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that personal medication records are accurately maintained. Ref: 5.2.1
	Response by registered person detailing the actions taken: All records have been brought up to date.
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 31 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that two staff routinely perform an accuracy check and sign handwritten entries on personal medication records and medicine administration records. Ref: 5.2.1
	Response by registered person detailing the actions taken: all hand written entries have two signatures.

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

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