Bradley Manor
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Announced Medicines Management Inspection of Bradley Manor

18 November 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An announced, post-registration, medicines management inspection took place on 18 November 2015 from 10:30 to 13:40.

The management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no significant areas of concern though some areas for improvement were identified and are set out in the quality improvement plan (QIP) within this report.

This inspection was underpinned by the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

For the purposes of this report, the term 'patients' will be used to described those living in Bradley Manor, which provides both nursing and residential care.

1.1 Actions/Enforcement Taken Following the Last Medicines Management Inspection

This was the first medicines management inspection of the home since registration on 16 July 2015.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action did not result from the findings of this inspection.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**2**	**1**

The details of the QIP within this report were discussed with Miss Amanda Mitchell, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

2.

Service Details

Registered Organisation/Registered Person: Healthcare Ireland (Belfast) Limited Mr Gilbert Yates	**Registered Manager:** Miss Amanda Celine Mitchell
Person in Charge of the Home at the Time of Inspection: Miss Amanda Mitchell	**Date Manager Registered:** 16 July 2015
Categories of Care: NH-DE, NH-I, RC-DE	**Number of Registered Places:** 76
Number of Patients Accommodated on Day of Inspection: 58	**Weekly Tariff at Time of Inspection:** £500 - £643

3. Inspection Focus

The inspection sought to determine if the following standards and themes have been met:

Standard 28: Management of Medicines
Standard 29: Medicines Records
Standard 31: Controlled Drugs

Theme 1: Medicines prescribed on a "when required" basis for the management of distressed reactions are administered and managed appropriately.

Theme 2: Medicines prescribed for the management of pain are administered and managed appropriately.

4. Methods/Process

Specific methods/processes used included the following:

Prior to the inspection the management of any incidents reported to RQIA since registration was reviewed. None had been reported.

We met with the registered manager, the deputy manager and the registered nurses on duty.

The following records were examined:

- medicines requested and received
- personal medication records
- medicine administration records
- medicines disposed of or transferred
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicine storage temperatures.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced post-registration care inspection dated 24 August 2015. The completed QIP was returned and was approved by the care inspector on 12 October 2015.

5.2 Review of Requirements and Recommendations from the Last Medicines Management Inspection

This was the first medicines management inspection of the home since registration on 16 July 2015.

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

A sample of medicines and medicine records were audited. The audits produced satisfactory outcomes indicating that medicines were administered as prescribed.

The management of medicines during a patient's admission to the home and discharge from the home was examined. Medicine details were confirmed in writing with the prescriber. However, for one admission the patient medication record did not correlate with the hospital discharge details. A requirement regarding the maintenance of personal medication records was made.

Systems to manage the ordering of prescribed medicines, to ensure that adequate supplies were available, were reviewed. For one patient, some nutritional supplements prescribed in hospital had not been obtained since admission. A requirement was made. All of the medicines examined at the inspection were labelled appropriately.

There were satisfactory arrangements for managing medicine changes, including high risk medicines such as warfarin and insulin.

Medicine records had generally been maintained in a satisfactory manner. Records of the prescribing, ordering, receipt, administration and disposal/transfer of medicines were maintained. Electronic personal medication records, administration records, records of receipt and care records were in use. In addition, medicines ordering will be completed on this system from December 2015 onwards. The process of verifying personal medication records involved two registered nurses which is good practice.

The receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Stock reconciliation checks were performed on controlled drugs which require safe custody, at each transfer of responsibility.

For patients prescribed a thickening agent for the management of swallowing difficulty, the prescribed consistency level was not always clearly referenced on the personal medication record. However, a care plan was in place and Speech and Language therapist (SALT) reports were also observed. A requirement regarding the maintenance of personal medication records was made.

Discontinued or expired medicines were discarded by two registered nurses into pharmaceutical clinical waste bins which are uplifted by a waste disposal contractor.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines, including Standard Operating Procedures for the management of controlled drugs were available. These had been reviewed following comments made in July 2015, when submitted to RQIA prior to registration.

Medicines were being managed by staff who had been trained and deemed competent. An induction process was in place. The registered manager advised that the impact of training will be monitored through supervision and appraisal. Training in medicines management is provided through completion of e-learning modules. Additional training on the management of syringe drivers had been provided by the trust.

Arrangements were in place to audit the practices for the management of medicines. A running stock balance is maintained for all medicines on the eMAR system. This system is dependent on staff accurately recording the receipt of medicines into the home. The registered manager also performs a medication audit and was aware that further work is necessary to ensure the accuracy of these records. A recommendation was made. The community pharmacist complements this audit activity by performing medicines audits and providing a written report of the outcome. The audit process was facilitated by the good practice of recording the date and time of opening on the medicine container.

Staff confirmed that compliance with prescribed medicines regimes was monitored and any omissions or refusals likely to have an adverse effect on the patients' health were reported to the prescriber.

There was a system in place to report, analyse and learn from incidents. No medicine related incidents had been reported.

Is Care Compassionate? (Quality of Care)

The records for a small number of patients who were prescribed medicines for the management of distressed reactions, on a "when required" basis, were examined. The name of the medicine and the frequency of dosing were recorded on the personal medication record. A care plan was in place. A record of each administration was recorded including the reason for and outcome of each administration. Staff were familiar with circumstances when to administer anxiolytic/ antipsychotic medicines and had the knowledge 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.

The management of medicines prescribed to manage pain were examined for a sample of patients. The medicines prescribed were recorded on the personal medication record and records indicated that they had been administered as prescribed. This included regularly prescribed transdermal opioid patches and analgesics which were prescribed for administration on a "when required" basis. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the patient was comfortable. Care plans were in place.

Areas for Improvement

The personal medication records must be accurately maintained and correlate with the prescriber's instructions. A requirement was made.

The management of medicines during a patient's admission to the home must be reviewed to ensure that robust systems are in place and all medicines are available for administration as prescribed. A requirement was made.

The audit system should be further developed to ensure that discrepancies in electronic records are identified. A recommendation was made.

Number of Requirements	**2**	**Number of Recommendations**	**1**

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with the registered manager, Miss Amanda Mitchell, as part of the inspection process. The timescales commence from the date of inspection.

The registered person/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered person/manager to ensure that all requirements and recommendations contained 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 your premises. 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.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person meets legislative requirements based on The DHPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

6.3 Actions Taken by the Registered Person/Registered Manager

The QIP should be completed by the registered person/registered manager and detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to **pharmacists@rqia.org.uk** and assessed by the inspector.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time **To be Completed by:** 18 December 2015	The registered person must ensure that the personal medication records are accurately maintained and correlate with the prescriber's instructions.
	Response by Registered Person(s) Detailing the Actions Taken: A review of all meducation records has been carried out . This will be monitored through internal audit .
Requirement 2 **Ref:** Regulation 13(4) **Stated:** First time **To be Completed by:** 18 December 2015	The registered person must ensure that the management of medicines during a patient's admission to the home is reviewed to ensure that robust systems are in place and all medicines are available for administration as prescribed.
	Response by Registered Person(s) Detailing the Actions Taken: All relevant staff have received supervision in relation to admission of a resident to the home. Two qualified staff to check all medication received into the home for any new admissions.
Recommendations	
Recommendation 1 **Ref**: Standard 28 **Stated:** First time **To be Completed by:** 18 December 2015	The audit system should be further developed to ensure that discrepancies in electronic records are identified.
	Response by Registered Person(s) Detailing the Actions Taken: The electronic system has been removed on the advice from Boots due to a potential risk of hacking . Paper copies have now replaced the electronic system and will be monitored through internal audit

Registered Manager Completing QIP	Amanda Mitchell	**Date Completed**	21.12.15
Registered Person Approving QIP	Gilbert Yates	**Date Approved**	21.12.15
RQIA Inspector Assessing Response	Rachel Lloyd	**Date Approved**	22/12/15

Please ensure this document is completed in full and returned to pharmacists@rqia.org.uk from the authorised email address