Inspection Report

9 April 2024

Bradley Manor

Type of service: Residential Care Home
Address: 420 Crumlin Road, Belfast, BT14 7GE
Telephone number: 028 9074 5164

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: Healthcare Ireland (Belfast) Ltd **Responsible Individual:** Ms Amanda Mitchell	**Registered Manager:** Mrs Julie Watson **Date registered:** 10 December 2018
Person in charge at the time of inspection: Mrs Julie Watson	**Number of registered places:** 21
Categories of care: Residential Care (RC): DE – dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 20
Brief description of the accommodation/how the service operates: Bradley Manor is a residential care home registered to provide health and social care for up to 21 residents. The home is situated in the same building as Bradley Manor nursing home.	

2.0 Inspection summary

An unannounced inspection took place on 9 April 2024, from 9.40am to 1.05pm. This 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.

The area for improvement identified at the last medicines management inspection was assessed as met. The areas for improvement identified at the last care inspection will be followed up at the next care inspection.

Based on the inspection findings one area for improvement was identified, details can be found in the report and the Quality Improvement Plan (QIP). Medicine records and medicine related care plans were well maintained. Whilst an area for improvement was identified, RQIA can conclude that overall, with the exception of a small number of medicines, the residents were administered their medicines as prescribed.

RQIA would like to thank the residents and 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, staff training and the auditing systems used to ensure the safe management of medicines. Discussions were held with 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 the senior care assistant and the manager.

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

Feedback methods included a staff poster and paper questionnaires which were provided for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no responses 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 28 November 2023		
Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022) (Version 1:2)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 33.3 **Stated:** First time	The registered person shall ensure that medicines in use are labelled to enable staff to positively identify each medicine.	**Met**
	Action taken as confirmed during the inspection: All medicines were identifiable. This area for improvement was assessed as met.	

Area for improvement 2 **Ref:** Standard 12.10 **Stated:** First time	The registered person shall ensure that residents are supervised at mealtimes in accordance with their assessed need. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**
Area for improvement 3 **Ref:** Standard 5 **Stated:** First time	The registered person shall ensure that records pertaining to Speech and Language (SALT) assessments are kept up to date to accurately reflect the needs of the resident. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.**	**Carried forward to the next inspection**

5.2 Inspection findings

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 practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times the residents' 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.

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, for example, at medication reviews or hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to state that they were accurate. A couple of minor discrepancies were highlighted and addressed immediately.

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.

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 distressed reactions was reviewed. Directions for use were recorded on the personal medication records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a resident's behaviour and was aware that this change may be associated with other factors. Records included the reason for and outcome of each administration.

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. Care plans were in place and reviewed regularly.

Care plans were in place when residents required insulin to manage their diabetes. There was sufficient detail to direct staff if the resident's blood sugar was outside the recommended range.

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

Medicine 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 they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage area was observed to be 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 a controlled drugs cabinet were available for use as needed. The temperature of the medicine storage areas was monitored and recorded to ensure that medicines were stored appropriately.

Satisfactory arrangements were in place for the safe disposal of medicines.

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.

A sample of medicine administration records was reviewed. Records were found to have been accurately 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 should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

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 medicines so that they could be easily audited. This is good practice. A small number of discrepancies were identified in the administration of liquid and inhaler preparations. These were discussed and advice provided, they should be appropriately monitored to ensure they are administered as prescribed. An area for improvement was identified.

Where residents have their medicines administered in food/drinks to assist administration, care plans detailing how the residents like to take their medicines were in place and the prescriber had provided written authorisation.

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 residents or residents returning from hospital. Written confirmation of the resident'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 learning shared with staff in order to prevent a recurrence.

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 they are supported. Policies and procedures should be up to date and readily available for staff.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

It was agreed that the findings of this inspection would be shared with staff for ongoing improvement.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	0	3*

* The total number of areas for improvement includes two which are carried forward for review at the next inspection.

The new area for improvement and details of the Quality Improvement Plan were discussed with Mrs Julie Watson, Registered Manager, as part of the inspection process. The timescale for completion commences from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022	
Area for improvement 1 **Ref:** Standard 12.10 **Stated:** First time **To be completed by:** Immediate and ongoing (29 November 2023)	The registered person shall ensure that residents are supervised at mealtimes in accordance with their assessed need. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Area for improvement 2 **Ref:** Standard 5 **Stated:** First time **To be completed by:** Immediate and ongoing (29 November 2023)	The registered person shall ensure that records pertaining to Speech and Language (SALT) assessments are kept up to date to accurately reflect the needs of the resident. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Area for improvement 3 **Ref:** Standard 30 **Stated:** First time **To be completed by:** From the date of the inspection onwards (9 April 2024)	The registered person shall ensure that the administration of liquid medicines and inhaler preparations is appropriately monitored to ensure they are administered as prescribed. Ref: 5.2.3 **Response by registered person detailing the actions taken:** A countdown audit has commenced to focus on inhalers. Liquid medication will now be measured at least monthly, this is being overseen by the Registered Manager and checked by Senior Management within Reg 29 visits.

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

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