The Regulation and Quality Improvement Authority

Inspection Report

20 April 2021

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) Limited **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 Residents to be accommodated on the ground floor
Categories of care: Residential Care (RC): DE – dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 21
Brief description of the accommodation/how the service operates: This is a residential care home which is registered to provide care for up to 21 residents living with dementia. This home is situated in the same building as Bradley Manor nursing home.	

2.0 Inspection summary

An unannounced inspection took place on 20 April 2021, between 10.40am and 2.45pm. 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 since the last care and medicines management inspections.

Although we identified an area for improvement, we can conclude that overall, the residents were being administered their medicines as prescribed. 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.

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. To complete the inspection: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines were reviewed.

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 records
- 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

The inspector met with the team leader and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff were warm and friendly and it was evident from their interactions 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. They spoke highly of the support given by management and the communication within the home.

Feedback methods included a staff poster to facilitate online feedback 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.

At the time of issuing this report, no questionnaires had been returned. No staff responses were received.

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 care inspection on 4 August 2020		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 6 **Stated:** First time	The registered person shall ensure the care plan for the identified resident is reviewed and updated to clearly reflect the plan of care with regards to managing distressed reactions.	**Met**
	Action taken as confirmed during the inspection: A sample of care records for the management of distressed reactions was examined. These were up to date and reflected the plan of care in place.	
Areas for improvement from the last medicines management inspection on 20 March 2019		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 31 **Stated:** First time	The registered person shall ensure that the management of warfarin is reviewed and monitored.	**Met**
	Action taken as confirmed during the inspection: The management of warfarin had been reviewed and was being appropriately monitored. Written confirmation of the current dose was available, two staff were involved in transcribing doses and running balances were maintained and found to be accurate.	
Area for improvement 2 **Ref:** Standard 6	The registered person shall ensure that the management of distressed reactions is reviewed and monitored.	**Met**

Stated: First time	**Action taken as confirmed during the inspection**: A sample of care records for the management of distressed reactions was examined. These included detail of medicines prescribed and their use and were specific to the resident. The management of distressed reactions was reviewed and monitored by the manager.	

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 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.

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 provide a double check that they are accurate.

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, 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. Records of administration were clearly recorded. The reason for and outcome of administration were recorded in the daily progress notes.

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.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time?

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

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 resident could be easily located. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

The disposal arrangements for medicines were reviewed. 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 medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. These records were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for review/audit.

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 appropriately in controlled drug record books.

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.
Residents, on occasion, may have their medicines administered covertly or in food/drinks to assist administration. Care plans detailing how the residents take their medicines were in place and prescribers had provided written authorisation for each resident.

Where a resident had been supplied their medicines in a monitored dosage system, the labelling did not allow staff to positively identify each individual medicine. This is necessary if, for example, a medicine is dropped or refused, to allow staff to record this accurately. Staff should only accept medicines where positive identification is possible and in line with policies and procedures. An area for improvement was identified.

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.

Records for recent admissions to the home were reviewed. Robust arrangements were in place to ensure that staff were provided with a list of prescribed medicines and this was shared with the community pharmacist. Medicines had been accurately received into the home and administered in accordance with the most recent directions. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

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.

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.

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

The medicine cups used to administer medicines to residents were often labelled as single use therefore; they should be discarded after each use. Staff advised that the cups are washed

after use and then reused. This matter was discussed and an assurance was provided that this practice would be reviewed.

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

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 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 regarding the management of medicines.

The outcome of this inspection concluded that all areas for improvement identified at the last medicines management and care inspections had been addressed. One new area for improvement was identified and is detailed in the quality improvement plan; it refers to labelling of medication enabling staff to positively identify each medicine.

Whilst one area for improvement was identified in relation to safe and effective care, we can conclude that overall, the residents were being administered their medicines as prescribed. 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 regarding the management of medicines.

Thank you to 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 Home Regulations (Northern Ireland) 2005 and the Residential Care Homes Minimum Standards (2011).

	Regulations	Standards
Total number of Areas for Improvement	0	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Julie Watson, Registered Manager, and also the peripatetic support manager, who listened to feedback by telephone, 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 Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 33.3 **Stated:** First time **To be completed by:** 27 April 2021	The registered person shall ensure that medicines in use are labelled to enable staff to positively identify each medicine. Ref: 5.2.3
	Response by registered person detailing the actions taken: The Registered Manager contacted the pharmacy on the same day and was supplied with a description of each medication. Arrangements were put in place that all future medications for this resident would be placed in boxes, this is in keeping with the current medication administration system within the home.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews