Unannounced Medicines Management Inspection Report
4 April 2017

Brae Valley

Type of service: Residential Care Home
Address: 2 Breda Terrace, Newtonbreda, Belfast BT8 7BY
Tel No: 028 9504 2940
Inspector: Judith Taylor

1.0 Summary

An unannounced inspection of Brae Valley took place on 4 April 2017 from 10.25 to 14.50.

The inspection sought to assess progress with any issues raised during and since the previous inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence that the management of medicines supported the delivery of safe care and positive outcomes for residents. Staff administering medicines were trained and competent. There were largely satisfactory systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. Two areas for improvement were identified in relation to the recording of new medicines information and the management of warfarin. Two recommendations were made.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure residents were receiving their medicines as prescribed. One area for improvement was identified in relation to the management of distressed reactions and a recommendation was stated for the second time.

Is care compassionate?

The management of medicines supported the delivery of compassionate care. Staff interactions were observed to be compassionate, caring and timely which promoted the delivery of positive outcomes for residents. There was evidence of good relationships between staff and residents. There were no areas of improvement identified.

Is the service well led?

The service was found to be generally well led with respect to the management of medicines. Written policies and procedures for the management of medicines were in place which supported the delivery of care. Systems were in place to enable management to identify and cascade learning from any medicine related incidents and medicine audit activity. Some further development of the audit process was necessary and a recommendation was made.

This inspection was underpinned by The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Joan Telford, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

1.2 Actions/enforcement taken following the most recent care inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 13 December 2016.

2.0 Service details

Registered organisation/registered person: Belfast HSC Trust / Mr Martin Joseph Dillon	**Registered manager:** See below
Person in charge of the home at the time of inspection: Ms Joan Telford	**Date manager registered:** Mr Gerry Robinson - Acting Manager, no application required
Categories of care: RC-DE (Dementia)	**Number of registered places:** 30

3.0 Methods/processes

Prior to inspection we analysed the following records:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents reported to RQIA since the last medicines management inspection.

We met with one resident, three care staff, two senior care staff and the manager.

A poster indicating that the inspection was taking place was displayed in the lobby of the home and invited visitors/relatives to speak with the inspector. No one availed of this opportunity during the inspection.

Fifteen questionnaires were issued to residents, resident's relatives/representatives and staff, with a request that these were completed and returned to RQIA within one week of the inspection.

A sample of the following records was examined during the inspection:

- 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
- medicines storage temperatures

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 13 December 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was approved by the care inspector. It will be validated at the next care inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 13 November 2014

Last medicines management inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 13(4) **Stated:** First time	The registered manager must review the management of bisphosphonate medicines to ensure they are administered separately from food or other medicines and records of administration are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: Staff confirmed that this had been reviewed following the last medicines management inspection, and that they were aware that these medicines must be administered separately from food or other medicines. They stated that the actual time of administration was recorded. These medicines had not been prescribed for some time, until recently.	

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 30 **Stated:** First time	The registered manager should review the management of distressed reactions to ensure a care plan and a reason for the administration and effect of administration is recorded on every occasion, for the relevant residents.	**Partially Met**
	Action taken as confirmed during the inspection: The sample of records examined indicated that a care plan was not in place for all residents who were prescribed these medicines. The reason for administration was recorded; however, the effect of administration was not recorded. **This recommendation was stated for a second time.**	
Recommendation 2 **Ref**: Standard 30 **Stated:** First time	The registered manager should review the management of the covert administration of medicines to ensure a care plan is put in place and the relevant records are maintained.	**Met**
	Action taken as confirmed during the inspection: Satisfactory arrangements were in place for the covert administration of medicines.	
Recommendation 3 **Ref**: Standard 30 **Stated:** First time	The registered manager should review the management of controlled drugs to ensure the policies and procedures for controlled drugs reflect current practice.	**Met**
	Action taken as confirmed during the inspection: These had been reviewed and updated following the last medicines management inspection.	
Recommendation 4 **Ref**: Standard 32 **Stated:** First time	The registered manager should closely monitor the management of the cold storage of medicines.	**Met**
	Action taken as confirmed during the inspection: Examination of the cold storage of medicines indicated that satisfactory medicine refrigerator temperatures were maintained and medicines were stored appropriately. A list of medicines which require refrigeration was also in place.	

4.3 Is care safe?

The manager advised that she had been appointed in March 2017. She confirmed that medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for care staff who had been delegated medicine related tasks. The impact of training and staff competency was monitored through team meetings, quarterly supervision and annual appraisal. Refresher training in medicines management was provided in the last two years and update training was planned. Staff had also received training on adult safeguarding and dementia.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines. Safe systems were in place for the acquisition and storage of prescriptions.

There were largely satisfactory arrangements in place to manage changes to prescribed medicines. The details were recorded on the personal medication records; however, two staff were not routinely involved in updating these records. This was discussed in relation to safe practice and a recommendation was made.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and discharge from the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

The management of high risk medicines was examined e.g. warfarin. Staff advised that the warfarin dosage regime is initially received by telephone and followed up in writing. This regime is recorded on a separate record; however, the transcribing does not include two staff. A separate administration record was also in use. The benefit of maintaining a running stock balance for this medicine was discussed. A recommendation regarding the management of warfarin was made.

Appropriate arrangements were in place for administering medicines in disguised form.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened. Medicine refrigerators were checked at regular intervals.

Areas for improvement

Two staff should be involved in the writing and updating of personal medication records. A recommendation was made.

The management of warfarin should be reviewed. A recommendation was made.

Number of requirements	0	Number of recommendations	2

4.4 Is care effective?

With the exception of a few liquid medicines, the sample of medicines examined had been administered in accordance with the prescriber's instructions. The manager advised that these would be closely monitored within the audit process.

When a resident was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. 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. Staff advised of the recent training which had been completed. The reasons for the administration were recorded. The outcome should also be recorded. A care plan detailing the management of distressed reactions was not in place for each resident prescribed these medicines. A recommendation was stated for a second time.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. Staff advised that the residents could verbalise any pain. A care plan was maintained. They provided an example of where one resident's pain management had been referred to the prescriber as adequate pain control had not been achieved, and the frequency of administration of analgesics had increased.

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

The majority of medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included paracetamol warnings and alerts for specific medicine instructions on personal medication records. In relation to the medicine administration records completed by care staff, some improvement was found to be necessary. This was discussed and agreed it would be monitored within the audit process.

Following discussion with the manager and staff, it was evident that when applicable, other healthcare professionals were contacted in response to residents' healthcare needs.

Areas for improvement

The management of distressed reactions should be reviewed. A recommendation was stated for a second time.

Number of requirements	0	Number of recommendations	1

4.5 Is care compassionate?

The administration of medicines to residents was completed in a caring manner, residents were given time to take their medicines and medicines were administered as discreetly as possible. Medicines were dispensed from their container, immediately prior to administration.

Staff provided details of some residents' preferences regarding the administration of their medicines and those who like to have their morning medicines at a later time, due to sleeping longer in the morning. Staff were aware of the time intervals between medicines.

Residents were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. They were treated courteously, with dignity and respect. Good relationships were evident.

It was not possible to ascertain residents' views and opinions regarding the management of their medicines.

As part of the inspection, questionnaires were issued to residents, resident's relatives/representatives and staff. No questionnaires were received by RQIA at the time of issuing this report.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

Staff confirmed that written policies and procedures for the management of medicines were in place. These were not examined in detail at the inspection. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

In relation to the regional safeguarding procedures, staff confirmed they were familiar with these and were aware of when incidents must be considered as reportable to the adult safeguarding lead.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. Medicine related incidents reported since the last medicines management inspection were discussed. There was evidence of the action taken and learning implemented following incidents.

A review of the internal audit records indicated that satisfactory outcomes had been achieved. However, it was noted that the audits on individual medicines focused on those that were supplied as tablets or capsules. It was advised that a variety of medicines formulations should be included. As some improvements were necessary in the completion of some medicine records and liquid medicines, the audit process should be further developed. A recommendation was made.

Following discussion with the manager and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that any resultant action was communicated to them as needed.

Areas for improvement

The audit process for medicines management should be developed. A recommendation was made.

Number of requirements	0	Number of recommendations	1

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ms Joan Telford, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/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 provider 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 the residential care 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Residential Care Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011). They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to RQIA web portal for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 30 **Stated:** Second time **To be completed by:** 4 May 2017	The registered manager should review the management of distressed reactions to ensure a care plan and a reason for the administration and effect of administration is recorded on every occasion, for the relevant residents.
	Response by registered provider detailing the actions taken: Care plans have been reviewed & updated to reflect management of distressed reactions and the reason for administration and the effect will be recorded for each resident. Regular audits will ensure procedures are followed.
Recommendation 2 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 4 May 2017	The registered provider should ensure that the transcribing of medicines information on personal medication records involves two members of trained staff and both initial the entry.
	Response by registered provider detailing the actions taken: The transcribing of medicines procedure has been reviewed and updated and staff made aware that two members of trained staff are to sign & date any changes to prescribed medicines. Regular audits will ensure procedures are followed.
Recommendation 3 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 4 May 2017	The registered provider should review the management of warfarin as detailed in the report.
	Response by registered provider detailing the actions taken: The management of warfarin has been reviewed & proforma as recommended by RQIA implemented with immediate effect to include the maintainence of a running stock balance and evidence of two staff signatures for all transcriptions.
Recommendation 4 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 4 May 2017	The registered provider should develop the audit process to ensure it covers all aspects of medicines management.
	Response by registered provider detailing the actions taken: The auditing process has been developed to include a variety of medicine formulations including creams, ointments, eyedrops etc.

Please ensure this document is completed in full and returned to RQIA web portal

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

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews