Unannounced Medicines Management Inspection Report
16 January 2018

Bruce House

Type of service: Residential Care Home
Address: 6a Duncairn Avenue, Belfast, BT14 6BP
Tel No: 028 9504 0570
Inspector: Judith Taylor

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a residential care home with 30 beds that provides care for residents with health care needs as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Belfast HSC Trust **Responsible Individual:** Mr Martin Joseph Dillon	**Registered Manager:** See Box Below
Person in charge at the time of inspection: Ms Liz Gaston (Senior Care Assistant) until 11.35 and Mrs Julie Grimes, Manager, thereafter	**Date manager registered:** Mrs Julie Grimes - application not yet submitted
Categories of care: Residential Care (RC) DE – dementia A – past or present alcohol dependence	**Number of registered places:** 30

4.0 Inspection summary

An unannounced inspection took place on 16 January 2018 from 10.40 to 14.30.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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).

The inspection assessed progress with any areas for improvement identified during and since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to medicines administration, medicine records, medicine storage and the management of controlled drugs.

One area requiring improvement was identified in relation to distressed reactions.

Residents were noted to be content in their surroundings and in their interactions with staff. There was a warm and welcoming atmosphere in the home.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	1

Details of the Quality Improvement Plan (QIP) were discussed with Ms Liz Gaston, Senior Care Assistant and Mrs Julie Grimes, 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.

4.2 Action/enforcement taken following the most recent care inspection

No further actions were required to be taken following the most recent inspection on 23 May 2017. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the home was reviewed. This included the following:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of incidents; it was ascertained that no incidents involving medicines had been reported to RQIA since the last medicines management inspection.

During the inspection the inspector met with three residents, one senior care assistant, one care assistant and the manager.

Ten questionnaires were provided for distribution to residents and their representatives for completion and return to RQIA. Staff were invited to share their views by completing an online questionnaire.

A poster informing visitors to the home that an inspection was being conducted was displayed.

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

Areas for improvement identified at the last medicines management inspection were reviewed and the assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 23 May 2017

The most recent inspection of the home was an unannounced care inspection. There were no areas for improvement identified as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection dated 17 September 2015

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 30 **Stated:** First time	The manager should closely monitor the management of thickened fluids to ensure records are fully and accurately maintained on every occasion.	**Met**
	Action taken as confirmed during the inspection: This has been reviewed and new systems developed and implemented. Specific charts to record administration of thickened fluids were now in place and their completion was monitored on a regular basis.	
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time	It is recommended that where medicines are prescribed on a "when required" basis for the management of distressed reactions the registered person should ensure that a care plan is maintained.	**Met**
	Action taken as confirmed during the inspection: Three residents' records and care plans were examined. There was some information regarding distressed reactions; however, further detail is necessary. Staff advised that they were very familiar with each resident and	

	how to manage any distressed reactions. The manager advised that she would update all the relevant care plans as soon as possible. Given these assurances, this area for improvement was assessed as met.	
Area for improvement 3 **Ref**: Standard 30 **Stated:** First time	It is recommended that where medicines are prescribed for the management of pain the registered person should ensure that this is referenced in a care plan.	**Met**
	Action taken as confirmed during the inspection: Three residents' records and care plans were examined. When medicines were prescribed to manage pain, these were listed in the residents' medicine related care plan. One resident's care plan included details of pain management; however, there was limited information in the other care plans. This was discussed in relation to ensuring that these clearly detailed if the resident could or could not communicate pain. The manager advised that she would update all the relevant care plans as soon as possible. Given these assurances, this area for improvement was assessed as met.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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 was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in dementia, medicines management and swallowing difficulty was provided in the last year.

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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

There were satisfactory arrangements in place to manage changes to prescribed medicines. Personal medication records and handwritten entries on medication administration records were updated by two members of staff. This safe practice was acknowledged.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed in February and March 2017.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home, when going on temporary absence from the home and discharge from the home.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. 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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. A care plan was maintained. Staff were reminded that obsolete warfarin regimes should be archived, with only the current regime kept in the medicines folder.

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. The medicine refrigerator was checked at regular intervals.

Areas of good practice

There were examples of good practice in relation to staff training, the management of medicines on admission, controlled drugs and the storage of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly or three monthly medicines were due.

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. The reason for and the outcome of administration were not recorded. An area for improvement was identified. See also Section 6.2.

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 most of the residents could communicate pain (see also Section 6.2) and also advised that the resident's pain would be discussed as part of the admission process.

The management of swallowing difficulty was examined. For those residents prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. Each administration was recorded and care plans and speech and language assessment reports were in place.

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. They advised that most residents took their medicines as prescribed and provided examples of where the prescriber had been contacted to change the formulation and/or time of administration of medicines, to assist with the resident's compliance.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate administration records for high risk medicines, sachets and analgesics; and double signatures for handwritten entries on personal medication records and medication administration records.

Practices for the management of medicines were audited throughout the month by the staff and management. This included running stock balances for several medicines. Staff routinely recorded the stock balance of medicines carried forward to the next medicine cycle. These records readily facilitated the audit process and this good practice was acknowledged. A quarterly audit was also completed by the community pharmacist.

Following discussion with the manager and staff, and a review of care files, it was evident that when applicable, other healthcare professionals were contacted in response to resident's healthcare needs.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

Details of the administration of medicines to manage distressed reactions should be recorded.

	Regulations	Standards
Total number of areas for improvement	0	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We observed the administration of medicines over the lunch time period. The medicines were administered to the residents in a caring manner and residents were given plenty of time to swallow their medicine. The medicines were administered as discreetly as possible.

We noted that the staff encouraged/assisted the residents with their meals and offered an alternative meal as needed.

Following discussion with staff they provided examples of when medicines were administered at a later or earlier time to facilitate the residents' preferences/needs; and confirmed that they were aware of and adhered to the prescribed time intervals between medicines.

Throughout the inspection, it was found that there were good relationships between the staff and the residents. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was clear from discussion and observation of staff, that the staff were familiar with the residents' likes and dislikes.

We acknowledged the warm and welcoming atmosphere in the home. In recent months, staff had adopted the Butterfly Scheme, to enhance person centred care. We observed the displayed memory boxes with items to reflect the resident's personal history and large display boards, with memorabilia which included various sports and music.

We met with three residents; they said they were happy in the home and could take their medicines. Comments included:

"I am well and get on ok."
"Things are good."
"They (staff) help you."

For those residents who could not verbalise their feelings in respect of their care, we noted them to be relaxed and comfortable in their surroundings and in their interactions with staff.

We met with staff throughout the inspection. Comments included:

"It's great here."
"The staff all work together."
"We have a good team."

Of the ten questionnaires which were left in the home to facilitate feedback from residents and their representatives, one was returned within the time frame. The responses indicated that they were very satisfied/satisfied with all aspects of the care provided.

No staff questionnaires were completed within the specified timeframe (two weeks).

Areas of good practice

Staff listened to residents and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

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 them.

The newly appointed manager had just taken up her post. She was familiar with the practices of the organisation. Following discussion with the manager and care staff, it was evident that staff were aware of their roles and responsibilities in relation to medicines management.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. They advised that any incidents were shared at shift handover, supervision and at team meetings. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

An effective auditing system was in place. Staff advised of the procedures which would be followed if a discrepancy or an area for improvement was identified.

Staff confirmed that any concerns in relation to medicines management were raised with management. They advised that management were open and approachable and willing to listen. They also stated that there were good working relationships within the home and with healthcare professionals involved in resident care.

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Liz Gaston, Senior Care Assistant and Mrs Julie Grimes, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 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 Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 6 **Stated:** First time	The registered person shall ensure that the reason for and the outcome of the administration of “when required” medicines for distressed reactions is recorded on each occasion. Ref: 6.5
To be completed by: 16 February 2018	**Response by registered person detailing the actions taken:** The specifics and outcome of this report has been communicated to all Band 5 Senior Care Assistants and discussed at a staff meeting on 13th February. Medication administration policy discussed with all Band 5 staff who were reminded of their responsibility to appropriately record administration of 'as required' medication in line with the medication administration policy. Where a resident requires administration of an 'as required' medication for distressed behaviour the presenting behaviour, the non pharmacological behavioural strategies implemented, the reason for administrating the 'as required medication' and the effectiveness of the medication in alleviating the distressed behaviours will be recorded in the residents daily records. Any resident who displays distressed behaviours will have a care plan in place detailing the behavioural strategies staff should use in responding to the distressed behaviour and when the 'as required' medication should be administered'. Care plans will be audited by the home manager, who will offer support to staff during individual supervision, team and governance meetings. The Trust has recently implemented the CLEAR Model to support the responses to resident's displaying distressed behaviours. All residents displaying distressed behaviour will be referred to CMHTOP who will support assessment, understanding and response to distressed behaviours by residents

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

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