Bannview House Care Home
RQIA ID: 11103
23 Bannview Road
Banbridge
BT32 3RL

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Unannounced Medicines Management Inspection of Bannview House Care Home

5 October 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced medicines management inspection took place on 5 October 2015 from 10:00 to 14:00.

On the day of the inspection 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.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015. Recommendations made prior to April 2015 relate to the DHSSPS Nursing Homes Minimum Standards, February 2008.

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

1.1 Actions/Enforcement Taken Following the Last Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last inspection on 17 October 2012.

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	1	2

The details of the QIP within this report were discussed with the Ms Helen Smyth, Nurse in Charge, as part of the inspection process. The timescales for completion commence from the date of inspection.

2. Service Details

Registered Organisation/Registered Person: Priory (Warrenpoint) Ltd Ms Caroline Denny	**Registered Manager:** Ms Roberta Wilson (Registration pending)
Person in Charge of the Home at the Time of Inspection: Ms Helen Smyth (Nurse in Charge)	**Date Manager Registered:** Not applicable
Categories of Care: NH-PH, NH-I, RC-I, NH-DE	**Number of Registered Places:** 80
Number of Patients Accommodated on Day of Inspection: 76	**Weekly Tariff at Time of Inspection:** £618

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the last medicines management inspection and 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 in this inspection include the following:

Prior to the inspection, the inspectors reviewed the management of medicine related incidents reported to RQIA since the previous medicines management inspection.

During the inspection the inspectors met with the registered nurses and staff on duty on each unit.

The following records were 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
Care plans
Training records
Medicines 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 care management inspection dated 6 May 2015. No requirements or recommendations resulted from this inspection.

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

Last Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref: Regulation 13(4)** **Stated twice**	Entries on the personal medication record must correlate with those on the MARs sheets.	**Met**
	Action taken as confirmed during the inspection: The entries on the personal medication records corresponded with those on the MARs sheets.	
Requirement 2 **Ref: Regulation 13(4)** **Stated once**	The registered manager must review the management of thickened fluids.	**Met**
	Action taken as confirmed during the inspection: The management of thickened fluids had been reviewed. A care plan was in place and an up to date Speech and Language assessment was held on file. The administration of thickened fluids was recorded on the MARs sheets by the registered nurses. Care assistants do not always record that fluids had been thickened. This was discussed for corrective action following the inspection.	

Last Inspection Statutory Requirements		Validation of Compliance
Requirement 3 **Ref: Regulation 13(4)** **Stated once**	The necessary improvements must be made to ensure that the personal medication records are fully maintained.	**Met**
	Action taken as confirmed during the inspection: Personal medication records were generally well maintained. One record had not been updated following the patient's readmission from hospital and this was discussed with the nurse on duty for corrective action following the inspection.	
Requirement 4 **Ref: Regulation 13(4)** **Stated once**	The registered manager must ensure that medication administration records are accurately maintained on all occasions.	**Met**
	Action taken as confirmed during the inspection: The medication administration records that were examined had been fully and accurately completed.	
Requirement 5 **Ref: Regulation 13(4)** **Stated once**	The registered manager must ensure that the medicines highlighted during this inspection are closely audited to ensure that they are administered in accordance with prescribed instructions.	**Met**
	Action taken as confirmed during the inspection: There was a robust auditing system in place. Medicines audited during the inspection showed satisfactory outcomes.	
Last Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref: Standard 40** **Stated once**	The manager should ensure that protocols for the use of home remedies, agreed with the patients' general practitioners are in place.	**Not applicable**
	Action taken as confirmed during the inspection: Home remedies were no longer used in the home.	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

Medicines were administered in accordance with the prescriber's instructions. The audit trails performed on a variety of randomly selected medicines at the inspection provided satisfactory outcomes. The nurse in charge was advised to monitor an inhaled medicine which showed a discrepancy.

Arrangements were in place to ensure the safe management of medicines during a patient's admission to the home and discharge or transfer from the home.

The process for the ordering and receipt of medicines was reviewed. A photocopy of the prescriptions was received into the home and checked for accuracy with the monthly drug order. Medicines were only ordered as needed and there were systems in place to ensure that there was a continuous supply of medicines.

At the time of the inspection, medicines were prepared immediately prior to their administration from the container in which they were dispensed. All of the medicines examined at the inspection were labelled appropriately.

Medicine records were generally well maintained so as to ensure that there was a clear audit trail. Records of the ordering, receipt, administration, non-administration and disposal of medicines were maintained. All of the personal medication records examined were written and signed by two registered nurses, this is safe practice. One record had not been updated following the patient's readmission from hospital. Staff were reminded that these records must be updated in a timely manner.

Areas of good practice included protocols for "when required" medicines, extra records for the administration of food supplements, application charts for transdermal patches and the routine recording of the date of opening of medicines facilitated the audit process.

The receipt, storage, 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. These checks also included some Schedule 4 (Part 1) controlled drugs, which is good practice. Robust arrangements for the management of controlled drugs were not in place in the Lisnaree unit. A transdermal patch that was prescribed for one patient had been applied late on two separate occasions over a three week period. On the morning of the inspection, only one senior carer had signed the controlled drugs record book for the administration of two controlled drugs; a witness to the administration should be present and sign the controlled drugs record book.

There were suitable systems in place to manage the administration of warfarin.

There were arrangements in place for the disposal of medicines which were discontinued or were unsuitable for use. There was evidence that controlled drugs were denatured prior to disposal using denaturing kits in three of the four units. The recording of the denaturing process in the fourth unit required improvement and this was discussed with the deputy manager.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines including Standard Operating Procedures for controlled drugs in Bannview House Care Home were in place. They were not examined in detail during this inspection.

The deputy manager advised that medicines were managed by staff who had been trained and deemed competent to do so, following a period of induction. The impact of training was monitored through team meetings, supervision and annual appraisal. A sample of records was provided. General medicines management training was completed on an annual basis. A list of the names, signatures and initials of registered nurses was maintained.

Practices for the management of medicines were audited on a regular basis. Running stock balances were maintained for warfarin and some other medicines which were not included in the 28 day blister packs. This is good practice. The house managers and community pharmacist had also completed audits. Satisfactory outcomes had been achieved.

There were procedures in place to report and learn from any medicine related incidents that had occurred in the home. The reported incidents had been managed satisfactorily.

Is Care Compassionate? (Quality of Care)

The records relating to a number of patients who were prescribed medicines on a “when required” basis for the management of distressed reactions were observed at the inspection. The parameters for administration of anxiolytic medicines were recorded on the personal medication records. In two of the four units, care plans were maintained and evaluated monthly. This should be developed across the home. The audits indicated that most of these medicines were administered infrequently. A reason for the administration and the outcome of the administration should be recorded on each occasion. From discussion with the staff, it was concluded that staff were familiar with circumstances when to administer anxiolytic medicines. Staff 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.

Medicines which were prescribed to manage pain were recorded on the patient’s personal medication record. Examination of the medicine administration records indicated that these medicines had been administered as prescribed, with the exception of the controlled drugs patch mentioned previously in the Lisnaree unit. This included regularly prescribed controlled drug patches and analgesics which were prescribed for administration on a “when required” basis. From discussion with the registered nurses and senior carer, it was evident that staff were aware of the signs, symptoms and triggers of pain in patients. Where pain controlling medicines were prescribed, staff were aware that ongoing monitoring is necessary to ensure the pain was well controlled and the patient was comfortable. Care plans and pain assessment tools were maintained and evaluated each month in three of the four units. This should be developed across the home.

Areas for Improvement

Robust arrangements for the management of controlled drugs must be in place in all units of the home.

The management of distressed reactions should be reviewed to ensure that: a care plan is in place; the reason for and outcome of any administration is recorded; and where administration is necessary on a regular basis, this should be reported to the prescriber. A recommendation was made.

The management of pain should be reviewed to ensure that a care plan is in place and a pain assessment tool is used where appropriate.

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

5.4 Additional Areas Examined

The medicine refrigerator temperatures were monitored and recorded daily and had been maintained within the required range of 2^{o}C to 8^{o}C.

Staff were reminded that all oxygen cylinders must be chained to a solid structure to prevent toppling. They must not be used to prop open doors.

6. Quality Improvement Plan

The issues identified during this inspection are detailed in the QIP. Details of this QIP were discussed with Ms Helen Smyth, Nurse in Charge, 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/s 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.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirement and recommendations set out in this report will provide the registered person/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Statutory Requirements	
Requirement 1 **Ref: Regulation 13(4)** **Stated: First time** **To be Completed by: 4 November 2015**	The registered person must ensure that robust arrangements for the management of controlled drugs are in place in all units in the home.
	Response by Registered Person(s) Detailing the Actions Taken: Procedures have been revisited with the residential unit manager. Formal supervision sessions have been undertaken with all staff within the residential unit with a responsibility for the administration of medicines. A monthly audit of MARS prescriptions with the emphasis on administrationof controlled drugs has been implemented.
Recommendations	
Recommendation 1 **Ref: Standard 18** **Stated: First time** **To be Completed by: 4 November 2015**	It is recommended that the management of distressed reactions is reviewed to ensure that all appropriate records are maintained.
	Response by Registered Person(s) Detailing the Actions Taken: A review of systems has taken place. All residents who have been prescribed PRN medication for the management of distressed reactions have individualised care plans and recording sheets incorporated into their care records.
Recommendation 1 **Ref: Standard 28** **Stated: First time** **To be Completed by: 4 November 2015**	It is recommended that the management of pain is reviewed to ensure that all appropriate records are maintained.
	Response by Registered Person(s) Detailing the Actions Taken: A review of systems has taken place. All residents who have been prescribed PRN medication for the management of pain have individualised pain assessments and care plans. An entry is made into the progress note record when PRN analgesia is given and an assessment of its effectiveness is also recorded.

Registered Manager Completing QIP	Roberta Wilson	**Date Completed**	09 11 15
Registered Person Approving QIP	Caroline Denny	**Date Approved**	10/11/2015
RQIA Inspector Assessing Response	Cathy Wilkinson	**Date Approved**	11/11/2015

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