Bridgeview
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Unannounced Medicines Management Inspection of Bridgeview

30 September 2015

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower, 5 Lanyon Place, Belfast, BT1 3BT
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1. Summary of Inspection

An unannounced medicines management inspection took place on 30 September 2015 from 11.00 to 12.45.

Overall 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 areas of concern. A Quality Improvement Plan (QIP) was not included in this report.

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

1.1 Actions/Enforcement Taken Following the Last Inspection

There were no further actions required to be taken following the last medicines management inspection on 4 February 2013.

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	**0**	**0**

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Bridgeview Mrs Rosemary Clarke	**Registered Manager:** Mrs Rosemary Clarke
Person in Charge of the Home at the Time of Inspection: Ms Olivia Scott, Senior Care Assistant, until 12:00 Mrs Rosemary Clarke, 12:00 – 12:45	**Date Manager Registered:** 19 December 2006
Categories of Care: LD and LD(E) with associated physical disability and sensory impairment	**Number of Registered Places:** 4
Number of Residents Accommodated on Day of Inspection: 4	**Weekly Tariff at Time of Inspection:** £528 - £1275

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 30: Management of medicines
Standard 31: Medicine records
Standard 33: Administration of medicines

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:

A review of medicine incident notifications showed that there had been no incidents reported since the last medicines management inspection.

During the inspection the inspector met with the registered manager and the two care staff on duty.

The following records were examined during the inspection:

Medicines requested and received	Medicine audits
Personal medication records	Policies and procedures
Medicine administration records	Care plans
Medicines disposed of or transferred	Training records.
Controlled drug record book	Medicines refrigerator 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 inspection dated 18 August 2015. The inspection resulted in no requirements or recommendations being made.

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

The last medicines management inspection of the home resulted in no requirements or recommendations being made.

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

Medicines were being administered in accordance with the prescribers' instructions. The audit trails performed on a variety of randomly selected medicines produced satisfactory outcomes.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Copies of prescriptions were held on file.

There was evidence that robust arrangements were in place to ensure the safe management of medicines during a resident's admission to the home. Medication details were confirmed in writing with the prescriber and personal medication record sheets had been completed and checked by two staff members. In addition, these had been signed by the prescriber.

Medicines were prepared immediately prior to their administration from the container in which they were dispensed. All of the medicines examined were available for administration and had been labelled appropriately.

Medicine records were legible and accurately maintained so as to ensure a clear audit trail. Records of the ordering, receipt, administration, disposal and transfer of medicines were well maintained. Epilepsy management plans for residents were in place when necessary.

Controlled drug record books and records of the stock reconciliation of controlled drugs which are subject to safe custody requirements were well maintained. Stock balances of these medicines had been reconciled on each occasion when the responsibility for safe custody was transferred.

Any medicines which had been discontinued or were unsuitable for use had been returned to the community pharmacist for disposal.

There were procedures in place to report and learn from any medicine related incidents that may occur in the home. There had been no reported incidents since the last medicines management inspection.

Is Care Effective? (Quality of Management)

Written policies and procedures for the management of medicines, including Standard Operating Procedures for the management of controlled drugs, were in place. These were reviewed in 2014.

Medicines were managed by staff who had been trained and deemed competent to do so. Medicines management training was provided by the registered manager. The impact of training had been monitored through ongoing supervision and appraisal. Competency assessments had been completed annually and were available for examination. Records of staff training in the management of buccal midazolam were in place dated April 2015.

There were arrangements in place to note any compliance issues with medicine regimes and staff confirmed that these would be reported to the prescriber.

Practices for the management of medicines had been reviewed regularly. A review of audit records indicated that satisfactory outcomes had been achieved. The audit process was facilitated by the good practice of recording the date and time of opening on the medicine container and recording running balances for some medicines, including nutritional supplements and inhaler preparations.

Is Care Compassionate? (Quality of Care)

The records for residents prescribed medication for administration “when required” for the management of distressed reactions were examined. Medicine administration records indicated that the medicines were being administered only occasionally and in accordance with the prescribers’ instructions. A care plan was in place and the parameters for administration were recorded on the personal medication record. The reason for and outcome of the administration of these medicines were recorded.

The records for several residents prescribed medication for the management of pain were examined. The medicine administration records indicated that the medicines were being administered in accordance with the prescribers’ instructions. The parameters for administration were recorded on personal medication records.

From discussion with the staff on duty, it was evident that staff were aware of the signs, symptoms and triggers of pain. The registered manager stated that residents cannot always tell staff if they are in pain, however staff were aware that ongoing monitoring is necessary to ensure that pain is well controlled and residents are comfortable. There were systems in place to report any increased frequency in the use, or lack of effect of pain management medicines to the resident’s prescriber. However, care plans did not detail how residents express pain or the prescribed analgesic.

Areas for Improvement

The registered manager agreed to ensure that care plans include the details of any medication prescribed for use in the management of pain, to include guidance for staff on how pain may be expressed by individual residents.

Number of Requirements:	**0**	**Number of Recommendations**:	**0**

5.4 Additional Areas Examined

Medicines were safely and securely stored in accordance with the manufacturers' instructions. However, the controlled drugs cupboard was not securely attached to the wall inside the locked medicine cupboard. The registered manager agreed to address this following the inspection and this was confirmed by telephone on 7 October 2015.

6. No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Rosemary Clarke	**Date Completed**	15/10/15
Registered Person	Rosemary Clarke	**Date Approved**	15/10/15
RQIA Inspector Assessing Response	**Rachel Lloyd**	**Date Approved**	**15/10/15**

Please provide any additional comments or observations you may wish to make below:

Please complete in full and returned to pharmacists@rqia.org.uk from the authorised email address