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Unannounced Medicines Management Inspection of Breffni Lodge

16 November 2015

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

An unannounced medicines management inspection took place on 16 November 2015 from 10.25 to 14.40.

The management of medicines was found to be safe, effective and compassionate. The outcome of the inspection found no areas of concern. Areas of good practice were acknowledged. 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 Medicines Management Inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the last inspection on 13 November 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	0	0

This inspection resulted in no requirements or recommendations being made. The findings of the inspection were discussed with the registered manager, Ms Regina Brady, as part of the inspection process and can be found in the main body of the report.

2. Service Details

Registered Organisation/Registered Person: Mr Mark John Uprichard	**Registered Manager:** Ms Regina Brady
Person in Charge of the Home at the Time of Inspection: Ms Regina Brady	**Date Manager Registered:** 16 May 2013
Categories of Care: RC-DE, RC-I	**Number of Registered Places:** 22
Number of Residents Accommodated on Day of Inspection: 19	**Weekly Tariff at Time of Inspection:** £470 - £530

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 included the following:

The management of medicine related incidents reported to RQIA since the last medicines management inspection were reviewed.

We met with the registered manager and one resident.

The following records were examined:

- medicines requested and received
- personal medication records
- medicines administration records
- medicines disposed of
- controlled drug record book
- medicine audits
- policies and procedures
- care plans
- training records
- medicine 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 inspection dated 29 September 2015. No requirements or recommendations resulted from the 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 once	The personal medication record sheets must be accurately maintained. The manager must monitor the completion of the personal medication record sheets in order to ensure accuracy.	**Partially Met**
	Action taken as confirmed during the inspection: The personal medication records examined at the inspection were well maintained and there was evidence that these were included in the audit process. The date of writing was not documented on a small number of these records and this was discussed with the registered manager. This recommendation was partially met, however, due to the assurances provided by the registered manager it was not stated for a second time.	
Requirement 2 **Ref**: Regulation 13(4) Stated once	The dates of administration of medicines must always be recorded.	**Met**
	Action taken as confirmed during the inspection: The date of administration of each medicine was recorded on the sample of medication administration records examined.	
Requirement 3 **Ref**: Regulation 13(4) Stated once	The receipts of medicines contained in multi-dose compliance aids must be fully recorded.	**Met**
	Action taken as confirmed during the inspection: There was evidence that when compliance aids were supplied, the receipt of each individual medicine was recorded.	

Requirement 4 **Ref**: Regulation 13(4) Stated once	A full record must be maintained of medicine transactions between the home and residents for self-administration.	**Met**
	Action taken as confirmed during the inspection: There was a detailed chart in place which detailed the transfer of medicines to the resident for self-administration. This was signed by staff and the resident.	
Last Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 32 Stated twice	Controlled drugs subject to safe custody requirements should always be reconciled by two members of staff at each handover of responsibility.	**Met**
	Action taken as confirmed during the inspection: The stock balances of controlled drugs which were stored in the controlled drug cabinet were checked at each shift change. The records were signed by two members of staff.	
Recommendation 2 **Ref**: Standard 30 Stated once	The pharmacist dispensing medicines into a multi-dose compliance aid should be requested to provide full descriptive details of each medicine in order to aid its identification by staff.	**Met**
	Action taken as confirmed during the inspection: There were no compliance aids in use. However, the registered manager advised of the procedures in place to ensure that all incoming medicines were clearly identifiable for staff and an example of this was provided at the inspection.	
Recommendation 3 **Ref**: Standard 30 Stated once	The manager should ensure that written Standard Operating Procedures are available for the management of controlled drugs.	**Met**
	Action taken as confirmed during the inspection: Written Standard Operating Procedures for controlled drugs had been developed and implemented. There was evidence that these procedures had been read and signed by staff.	

Recommendation 4 **Ref**: Standard 30 Stated once	Diazepam and warfarin should be included in the home's auditing arrangements.	**Met**
	Action taken as confirmed during the inspection: Each of these medicines was included in the audit process. The stock balances of diazepam and warfarin were checked every day.	
Recommendation 5 **Ref**: Standard 31 Stated once	In the absence of the prescriber's signature, two designated staff members should initial or sign handwritten entries on the medication administration record sheets.	**Partially Met**
	Action taken as confirmed during the inspection: There was evidence that two staff signatures had been recorded on recent handwritten entries on the medication administration records. However, examination of previous records indicated that this had not occurred on every occasion. This was discussed with the registered manager, who stated that this was the expected practice and had been identified within their audit process. This recommendation was partially met, however, due to the assurances provided by the registered manager this recommendation was not stated for a second time.	

5.3 The Management of Medicines

Is Care Safe? (Quality of Life)

The outcomes of the audit trails performed on medicines produced satisfactory outcomes, indicating that medicines were administered as prescribed. Bisphosphonate medicines had been administered in accordance with the manufacturers' instructions.

There was evidence of the arrangements to ensure the safe management of medicines during a resident's admission to the home and discharge from the home. Medicine details were confirmed with the prescriber.

Systems to manage the ordering of prescribed medicines, to ensure that adequate supplies were available, were reviewed. These were found to be satisfactory. All of the medicines examined at the inspection were labelled appropriately.

There were robust arrangements for managing medicine changes, including high risk medicines such as warfarin; all changes were confirmed in writing.

Most of the medicine records were legible and accurately maintained so as to ensure that there was a clear audit trail. Some issues to address were identified on the personal medication records and medication administration records. It was agreed that these would be addressed later on the day of the inspection.

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. The good practice of including other controlled drugs which do not require safe custody, in this process, was acknowledged.

The arrangements for self-administered medicines were reviewed. A risk assessment had been completed. The medicine records clearly stated which medicines were self-administered and there was a system in place to monitor compliance and safe storage.

Any medicines which were discontinued or were unsuitable for use were returned to the community pharmacy for disposal.

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 in Breffni Lodge were in place. The registered manager advised that these were currently under review.

Medicines were managed by staff who had been trained and deemed competent. The registered manager advised that the impact of training was monitored through supervision and annual appraisal. Staff competency in medicines management was reviewed every three months. Recent training had included the management of diabetes and dysphagia. A list of the names, initials and sample signatures of staff responsible for administering medicines was maintained.

There were procedures in place to audit the management of medicines. This consisted of a daily audit on two residents' medicines, running stock balances for medicines supplied as tablets, capsules or sachets and a quarterly audit by the community pharmacist. The audit process was facilitated by the good practice of recording the date of opening on the medicine container and recording the stock balance carried forward to the new medicine cycle.

The registered manager advised of the procedures in place to manage any non-compliance with prescribed medicine regimes which may have an adverse effect on the residents' health; this was reported to the prescriber and other health care professionals.

There were arrangements for staff to report and learn from any medicine related incidents that may occur in the home. The reported medicine related incidents were discussed.

Is Care Compassionate? (Quality of Care)

The records pertaining to the administration of medicines prescribed on "when required" basis for the management of distressed reactions, were reviewed. The name of the medicine was documented on the personal medication record and the frequency of dosing was recorded. The evidence indicated that these medicines had not been required for several months. A written protocol detailing the parameters for the administration was in place; it was agreed that this information would also be recorded in a care plan. From discussion with staff, it was concluded that staff were familiar with circumstances when to administer anxiolytic medicines and were aware that a change in a resident's behaviour may be associated with pain.

The sample of records examined indicated that medicines which were prescribed to manage pain were recorded on the resident's personal medication record and had been administered as prescribed. This included regularly prescribed controlled drug patches and analgesics which were prescribed for administration on a "when required" basis. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. A written protocol detailing the management of pain, and also a separate form to record the area of pain was in place. A pain assessment tool was available for use as needed. Care plans in relation to pain management were maintained.

Areas for Improvement

There were no areas identified for improvement.

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

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager	Regina Brady	**Date Completed**	14/12/15
Registered Person	Mark Uprichard	**Date Approved**	15/12/15
RQIA Inspector Assessing Response	**Judith Taylor**	**Date Approved**	**16/12/15**

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

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