Unannounced Medicines Management Inspection Report
3 October 2016

Bramblewood Care Centre

Type of Service: Nursing Home
Address: 201 Gransha Road, Bangor, BT19 7RB
Tel no: 028 9145 4357
Inspector: Cathy Wilkinson

1.0 Summary

An unannounced inspection of Bramblewood Care Centre took place on 3 October 2016 from 10.00 to 12.30.

This was the first medicines management inspection to the home since it was re-registered in April 2016, following a change of ownership and registration of a new provider.

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 patients. Staff administering medicines were trained and competent. There were systems in place to ensure the management of medicines was in compliance with legislative requirements and standards. It was evident that the working relationship with the community pharmacist, the knowledge of the staff and their proactive action in dealing with any issues enables the systems in place for the management of medicines to be robust. There were no areas of improvement identified.

Is care effective?

The management of medicines supported the delivery of effective care. There were systems in place to ensure patients were receiving their medicines as prescribed. Comprehensive care plans for the management of specific medicines and medical conditions were in place. There were no areas of improvement identified.

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 patients. Patients consulted with confirmed that they were administered their medicines appropriately. There were no areas of improvement identified.

Is the service well led?

The service was found to be 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 share learning from any medicine related incidents and medicine audit activity. There were no areas of improvement identified.

This inspection was underpinned by The Nursing Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

1.1 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 were discussed with Ms Jacqueline Bowen, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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

1.2 Actions/enforcement taken following the most recent estates inspection

Other than those actions detailed in the QIP there were no further actions required to be taken following the most recent inspection on 14 July 2016.

2.0 Service details

Registered organisation/registered person: Burnview Healthcare Ltd Mrs Briege Agnes Kelly	**Registered manager:** Ms Jacqueline Bowen
Person in charge of the home at the time of inspection: Ms Jacqueline Bowen	**Date manager registered:** 01 April 2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 35

3.0 Methods/processes

Prior to inspection the following records were analysed:

- 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 two patients, two registered nurses and the registered 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.

A sample of the following records was examined:

- 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 14 July 2016

The most recent inspection of the home was an announced estates inspection. The completed QIP was returned and approved by the estates inspector. This QIP will be validated by the estates inspector at their next inspection.

4.2 Review of requirements and recommendations from the last medicines management inspection dated 17 August 2015

Last medicines management inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 26 **Stated:** First time	It is recommended that the registered person should ensure that the management of distressed reactions is reviewed to ensure that the outcome of administration of medicines is recorded.	**Met**
	Action taken as confirmed during the inspection: There were no patients that experienced distressed reactions at the time of the inspection; however the registered manager explained that the reason and outcome of the administration of medicines would be recorded. There were specific forms on the medicine file for recording this information.	

Recommendation 2 **Ref:** Standard 26 **Stated:** First time	It is recommended that the registered person should ensure that pain management is considered in the management of distressed reactions.	**Met**
	Action taken as confirmed during the inspection: Part of the pain management policy in the home references distressed reactions and directs staff to consider pain management when patients are distressed. The staff on duty confirmed that pain management would be considered when a patient is distressed.	
Recommendation 3 **Ref:** Standard 28 **Stated:** First time	It is recommended that the registered person ensures that pain assessments are completed as part of the admission procedure when appropriate.	**Met**
	Action taken as confirmed during the inspection: Staff advised that a pain assessment would be completed on admission. A range of pain assessment tools were noted on the medicine files.	

4.3 Is care safe?

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for registered nurses. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed. Refresher training in palliative care and e-learning on the management of medicines is planned for later in the 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.

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 registered nurses. This safe practice was acknowledged.

There were procedures in place to ensure the safe management of medicines during a patient's admission to 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. insulin.

Discontinued or expired medicines were disposed of appropriately. Discontinued controlled drugs were denatured and rendered irretrievable prior to disposal. The registered manager was reminded that the disposal record or the controlled drugs record book should document that the controlled drugs had been denatured prior to disposal.

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 and oxygen equipment were checked at regular intervals.

Areas for improvement

No areas for improvement were identified during the inspection.

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

4.4 Is care effective?

Most of the medicines in the home had been commenced on the morning of the inspection. The small sample of medicines that could be audited 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, monthly or three monthly medicines were due.

None of the patients currently required any medicines for distressed reactions. However, the registered manager advised that when a patient 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 patient's behaviour and were aware that this change may be associated with pain. The reason for and the outcome of administration were recorded and a care plan was maintained.

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 patient was comfortable. Staff advised that most of the patients could verbalise any pain, and a pain tool was used as needed. A care plan was maintained. Staff also advised that a pain assessment is completed as part of the admission process.

The management of swallowing difficulty was examined. For those patients prescribed a thickening agent, this was recorded on their personal medication record and included details of the fluid consistency. The 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 patient's health were reported to the prescriber.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included extra records for the administration of "when required" medicines, transdermal patch application, and the administration of insulin.

Practices for the management of medicines were audited throughout the month by the staff and management. The registered manager advised that a new audit tool was in the process of being drafted. In addition, a quarterly audit was completed by the community pharmacist.

Following discussion with the registered manager and staff, it was evident that when applicable, other healthcare professionals are contacted in response to the healthcare needs of patients.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.5 Is care compassionate?

The administration of medicines to several patients was observed during the inspection. The nurse administering the medicines spoke to the patients in a kind and caring manner. Patients were given time to swallow each medicine. Extra time and attention was given to patients who had difficulty swallowing some of the medicines. Medicines were prepared immediately prior to their administration from the container in which they were dispensed.

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

The patients spoken to said that they had no concerns in relation to the management of their medicines and were very complimentary of staff.

Comments included:

- “They’re very good here.”
- “The nurses are very kind.”

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?

Written policies and procedures for the management of medicines were in place and had been reviewed following the change of ownership of the home. Following discussion with staff it was evident that they were familiar with the policies and procedures and that any updates were highlighted to staff.

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.

The audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken and learning which had resulted in a change of practice.

Following discussion with the registered manager, registered nurses 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.

Areas for improvement

No areas for improvement were identified during the inspection.

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

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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.

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