Inspection Report
20 January 2021

Bluegate Lodge

Type of Service: Residential Care Home
Address: 1 Plantation Road, Garvagh
BT51 5ES
Tel No: 028 2955 7512
Inspector: Helen Daly

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 this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 What we look for

2.0 Profile of service

This is a residential care home which is registered to provide care for up to five residents.

3.0 Service details

Organisation/Registered Provider: Bluegate Lodge **Responsible Individual:** Mrs Mairead Brolly	**Registered Manager and date registered:** Mrs Mairead Brolly 24 August 2010
Person in charge at the time of inspection: Mrs Mairead Brolly	**Number of registered places:** 5 The home is approved to provide care on a day basis only for three persons
Categories of care: Residential Care (RC): I – old age not falling within any other category PH – physical disability other than sensory impairment PH (E)– physical disability other than sensory impairment – over 65 years	**Total number of residents in the residential care home on the day of this inspection:** 5

4.0 Inspection summary

An unannounced medicines management inspection took place on 20 January 2021 from 11.35 to 13.30.

This inspection was undertaken to determine the progress made in addressing the areas identified for improvement (with regards to medicines management) at the last inspection (6 October 2020) and to determine if the improvements had been sustained.

Areas for improvement with regards to care issues, identified at the last care inspection (8 September 2020) will be reviewed at the next care inspection.

At the last inspection, RQIA were concerned that some aspects of the management of medicines in Bluegate Lodge were below the standard expected. Concerns were noted in the administration of medicines, medicine records, staff training and the governance arrangements in the home.

The responsible individual and deputy manager were invited to attend a serious concerns meeting in RQIA on 12 October 2020 to discuss the concerns identified.

During the meeting, the responsible individual provided details of the action plans to address the concerns raised. Assurance was given that the concerns were being addressed. Following the meeting RQIA decided to allow a period of time for the home to demonstrate that the improvements had been made and advised that a further inspection would be undertaken to ensure that the issues had been effectively addressed. RQIA informed the responsible individual that enforcement action may be considered if the issues were not addressed and the improvement sustained.

The following areas were examined during this inspection:

- personal medicine records, medicine administration records and records of medicines received into the home
- controlled drugs
- medicines administration
- care planning in relation to pain
- medicines management training
- the governance and auditing systems in relation to medicines management .

We were assured that medicines were being administered as prescribed and that the necessary improvements had been implemented and sustained. No areas for improvement with regards to the management of medicines were identified.

Detailed feedback was provided to the responsible individual who advised that they fully understood the improvements must be sustained.

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	1*	3*

*The total number of areas for improvement includes one under the Regulations and three under the Standards which have been carried forward for review at a future care inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Mairead Brolly, Responsible Individual, as part of the inspection process. The timescales for completion commence from the date of the care inspection.

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 service was reviewed. This included the following records:

- notifiable events since the last inspection
- the registration status of the home
- written and verbal communication received since the last inspection
- the returned QIP from the last inspection
- the last inspection report

During the inspection we met with one care assistant and the responsible individual.

In order to reduce footfall in the home we remained in one room throughout the inspection and did not meet with residents.

Ten questionnaires were left in the home to obtain feedback from residents and residents' representatives. A poster was displayed for staff inviting them to provide feedback to RQIA on-line. One response was received from a resident. They indicated that they were "very satisfied" with all aspects of the care provided.

A sample of the following records was examined during the inspection:

- records for the prescribing, administration, receipt and disposal of medicines
- the controlled drug record book
- care records pertaining to the management of pain
- training records and competency assessments with regards to medicines management
- medicine related audits

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

As agreed with the care inspector, areas for improvement with regards to care related issues were not reviewed at this inspection and were carried forward for review at the next care inspection.

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 last inspection (6 October 2020)

Areas for improvement from the last inspection		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** Third and final time	The registered person must ensure that records of the administration of all medicines are completed accurately.	**Met**
	We reviewed the medication administration records for all five residents. They had been completed accurately.	
Area for improvement 2 **Ref**: Regulation 21.(1) (b) **Stated:** First time	The registered person shall not employ a person to work at the residential care home unless they have obtained the information and documents specified in paragraphs 1 to 7 of Schedule 2.	**Carried forward to the next care inspection**
	The responsible individual advised that no new staff had been recruited since the last inspection**.** **Action required to ensure compliance with this Regulation was not reviewed as part of the inspection. This will be carried forward for review at the next care inspection.**	
Area for improvement 3 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall implement a robust audit tool which covers all aspects of the management and administration of medicines. Where discrepancies are identified action plans should be developed and implemented.	**Met**
	Action taken as confirmed during the inspection: Records of the weekly audits were available for inspection. Any issues identified were addressed immediately.	

Area for improvement 4 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall ensure that records of all medicines received into the home are accurately maintained.	**Met**
	Action taken as confirmed during the inspection: We reviewed the medication order and receipt books. There was evidence that they had been accurately maintained.	
Area for improvement 5 **Ref:** Regulation 20 (1)(c) **Stated:** First time	The registered person shall ensure that staff receive further training and competency assessment on all aspects of the management of medicines	**Met**
	Action taken as confirmed during the inspection: Records of staff training and competency assessment were available for 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 31 **Stated:** Second time	The registered provider should ensure that personal medication records and all new entries are checked for accuracy and signed by two competent members of staff.	**Met**
	There was evidence that personal medication records were verified and signed by two trained staff when they were written/rewritten. A small number of updates had not been signed to ensure accuracy. The responsible individual advised that this would be addressed following the inspection and closely monitored through the audit process. Due to the improvements noted and the assurances provided this area for improvement was assessed as met.	
Area for improvement 2 **Ref**: Standard 20.11 **Stated:** Second time	The registered person shall monitor the quality of services in accordance with the home's written procedures and complete a monitoring report on a monthly basis. This report summarises any views of residents ascertained about the quality of the service	**Carried forward to the next care inspection**

	provided, and any actions taken by the registered person or the registered manager to ensure that the organisation is being managed in accordance with minimum standards.	
	Action required to ensure compliance with this Standard was not reviewed as part of the inspection. This will be carried forward for review at the next care inspection.	
Area for improvement 3 **Ref**: Standard 28.3 **Stated:** First time	The registered person promotes safe and healthy working practices through the provision of information, training, supervision and monitoring of staff in the following areas: • Infection control • Control of Substances Hazardous to Health (COSHH)	**Carried forward to the next care inspection**
	Action required to ensure compliance with this Standard was not reviewed as part of the inspection. This will be carried forward for review at the next care inspection.	
Area for improvement 4 **Ref**: Standard 8 **Stated:** First time	Records are kept in accordance with professional and legislative requirements on each resident's situation, actions taken by staff and reports made to others.	**Carried forward to the next care inspection**
	Action required to ensure compliance with this Standard was not reviewed as part of the inspection. This will be carried forward for review at the next care inspection.	
Area for improvement 5 **Ref:** Standard 6 **Stated:** First time	The registered manager should ensure that care plans for the management of pain are in place.	**Met**
	Action taken as confirmed during the inspection: Care plans for the management of pain were in place.	
Area for improvement 6 **Ref:** Standard 30 **Stated:** First time	The registered person shall review the management of controlled drugs to ensure that: • records are maintained in a bound book with pages sequentially numbered. • staff physically count the controlled drugs at administration and handover.	**Met**

	Action taken as confirmed during the inspection: Records for controlled drugs were maintained in a bound book with pages sequentially numbered. The responsible individual advised that staff physically count controlled drugs at administration and at each handover of responsibility.	

6.2 Inspection findings

6.2.1 Personal medication records and medication administration records

Personal medication records were in place for each resident. These contained a list of all prescribed medicines with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals e.g. medication reviews, transfers to hospital.

We found that the personal medication records were up to date and had been verified and signed by two trained staff to ensure accuracy of transcribing at the time of writing/rewriting. A small number of updates had not been signed; the responsible individual advised that this would be discussed with staff and monitored through the audit process.

It is important to have a clear record of which medicines have been administered to residents to ensure that they are receiving the correct prescribed treatment. The medication administration records were reviewed for all five residents. We found that they had been accurately maintained. There were no missed signatures/unexplained gaps in the administration records. Reminders were in place to ensure that medicines which were prescribed to be administered on alternate days or at weekly intervals were administered as prescribed. The audits completed at the inspection indicated that medicines were administered as prescribed.

6.2.2 Records of medicines received into the home

We found that records for the receipt of medicines had been accurately maintained. This is necessary to ensure that there is a clear audit trail to evidence that medicines are being administered as prescribed.

6.2.3 Controlled drugs

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a bound book with pages sequentially numbered in order to provide a clear audit trail.

The responsible individual advised that balances were checked at each administration and at shift handover. The audits completed at the inspection indicated that records for the administration of controlled drugs had been accurately maintained.

6.2.4 Care plans for the management of pain

All residents should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, antibiotics, warfarin, modified diets, self-administration, refusals etc.

The management of pain was reviewed for two residents. The responsible individual advised that staff were familiar with how each resident expressed their pain and that additional pain relief was administered when required. Care plans to direct the required care were in place.

6.2.5 Staff training and competency assessment

To ensure that residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The responsible individual has a responsibility to check that staff are competent in managing medicines and that staff are supported.

Following the last inspection the responsible individual discussed the management of medicines with each care assistant. Staff training was provided in September 2020 and competency assessments were completed in October 2020. Records were available for inspection.

6.2.6 The governance and auditing systems in relation to medicines management

Following the last inspection a comprehensive audit tool which covered all aspects of the management of medicines was developed. Each resident's medication records and medicines were audited weekly. The outcomes of these audits indicated that medicines were being managed effectively and administered as prescribed.

Medicines had been accurately received into the home, dates of opening were recorded and only one supply of each medicine was in use. These practices readily facilitate a clear audit trail. The audits completed at the inspection indicated that medicines were administered as prescribed.

Areas of good practice

Areas of good practice included the standard of record keeping and the governance and auditing systems.

Areas for improvement

No areas for improvement with regards to medicines management were identified at this inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.3 Conclusion

There was evidence that all areas for improvement with regards to medicines management had been addressed. The responsible individual was reminded that the improvements must be sustained.

Residents were administered their medicines as prescribed.

We would like to thank the residents and staff for their assistance throughout the inspection.

7.0 Quality improvement plan

Areas for improvement identified at the last care inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Mairead Brolly, Responsible Individual, as part of the inspection process. The timescales commence from the date of the care 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 nursing 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).

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 21.(1) (b) **Stated:** First time **To be completed by:** From the date of the inspection	The registered person shall not employ a person to work at the residential care home unless they have obtained the information and documents specified in paragraphs 1 to 7 of Schedule 2.
	Response by registered person detailing the actions taken: Action required to ensure compliance with this Regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection. Ref: 6.1
Action required to ensure compliance with Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 20.11 **Stated:** Second time **To be completed by:** From the date of inspection	The registered person shall monitor the quality of services in accordance with the home's written procedures and complete a monitoring report on a monthly basis. This report summarises any views of residents ascertained about the quality of the service provided, and any actions taken by the registered person or the registered manager to ensure that the organisation is being managed in accordance with minimum standards.
	Response by registered person detailing the actions taken: Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection Ref: 6.1
Area for improvement 2 **Ref**: Standard 28.3 **Stated:** First time **To be completed by:** From the date of inspection	The registered person promotes safe and healthy working practices through the provision of information, training, supervision and monitoring of staff in the following areas: • Infection control • Control of Substances Hazardous to Health (COSHH)
	Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection. Ref: 6.1

Area for improvement 3 **Ref**: Standard 8 **Stated:** First time **To be completed by:** From the date of the inspection	Records are kept in accordance with professional and legislative requirements on each resident's situation, actions taken by staff and reports made to others. **Action required to ensure compliance with this Standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.** Ref: 6.1

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