The Regulation and Quality Improvement Authority

Unannounced Medicines Management Inspection Report 11 September 2017

Breffni Lodge

Type of service: Residential Care Home
Address: 3 Wandsworth Road, Belfast, BT4 3LS
Tel No: 028 9065 3335
Inspector: Judith Taylor

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a residential care home with 22 beds that provides care for residents living within the categories of care as detailed in Section 3.0.

3.0 Service details

Organisation/Registered Provider: Breffni Lodge **Responsible Individual:** Mr Mark John Uprichard	**Registered Manager:** Ms Regina Brady
Person in charge at the time of inspection: Ms Regina Brady	**Date manager registered:** 16 May 2013
Categories of care: Residential Care (RC) I – Old age not falling within any other category DE – Dementia	**Number of registered places:** 22

4.0 Inspection summary

An unannounced inspection took place on 11 September 2017 from 10.20 to 14.00.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, 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).

The inspection assessed progress with any areas for improvement identified since the last medicines management inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to the governance arrangements for medicines, medicines administration, medicine records, storage and the management of controlled drugs. It was acknowledged that safe systems for medicines management continued to be in place as identified at this and the previous medicines management inspection.

No areas for improvement were identified.

Residents advised that they were content with the management of their medicines and the care provided to them.

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	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Regina Brady, 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.

4.2 Action/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 23 March 2017. Other than those actions detailed in the QIP no further actions were required to be taken. 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 home was reviewed. This included the following:

- recent inspection reports and returned QIPs
- recent correspondence with the home
- the management of medicine related incidents.

During the inspection we met with two residents, two members of care staff and the registered manager.

A poster informing visitors to the home that an inspection was being conducted was displayed.

A total of 15 questionnaires were provided for distribution to residents, their representatives and staff for completion and return to RQIA.

A sample of the following records was 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
- policies and procedures
- care plans
- training records
- medicines storage temperatures

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 the most recent inspection dated 23 March 2017

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

6.2 Review of areas for improvement from the last medicines management inspection dated 16 November 2015

There were no areas for improvement identified as a result of the last medicines management inspection.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Medicines were managed by staff who have been trained and deemed competent to do so. The impact of training was monitored through the outcomes of the audit process, team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in dementia and diabetes awareness had been provided in 2016. In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed in June 2017.

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. Antibiotics and newly prescribed medicines had been received into the home without delay. Satisfactory arrangements were in place for the acquisition and storage of prescriptions.

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 members of staff. This safe practice was acknowledged.

There were procedures in place to ensure the safe management of medicines during a resident's admission to the home and discharge from 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.

Robust arrangements were observed for the management of high risk medicines e.g. warfarin. The use of separate administration charts was acknowledged.

Discontinued or expired medicines were disposed of appropriately.

Medicines were stored safely and securely and in accordance with the manufacturer's instructions. Medicine storage areas were clean, tidy and well organised. Temperatures of the medicine storage areas were monitored on a daily basis. There were systems in place to alert staff of the expiry dates of medicines with a limited shelf life, once opened.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment, the management of medicines on admission, medicines storage and controlled drugs.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There were arrangements in place to alert staff of when doses of weekly medicines were due.

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 resident was comfortable. Staff advised that some of the residents could verbalise their pain, and a pain assessment tool was used as needed. Details were recorded in a care plan.

On some occasions, the administration of medicines process required review. It was found that some early morning medicines were being prepared for administration by one member of staff and then administered by another member of staff. This practice is unsafe. The registered manager provided assurances that this practice would cease immediately and hence an area for improvement was not made.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the resident's health were reported to the prescriber. Details regarding one resident's non-compliance and review were provided.

Medicine records were well maintained and facilitated the audit process. Areas of good practice were acknowledged. They included separate sheets to record medicine changes and 'when required' medicines.

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

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Appropriate arrangements were in place to facilitate residents responsible for the self-administration of medicines.

The administration of medicines to residents was completed in a caring manner, residents were given time to take their medicines.

It was evident that there was a good rapport between residents and staff. The staff treated the residents with respect and their approach was friendly and kind.

The residents we met with spoke positively about the management of their medicines and the overall care provided in the home. One comment made regarding care delivery was shared with the registered manager for action as required.

Whilst questionnaires had been left in the home for distribution to residents, their representatives and staff, no questionnaires had been returned to RQIA within the specified timeframe, or at the time of issuing this report.

Areas of good practice

Staff listened to residents and relatives and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

Written policies and procedures for the management of medicines were in place. Some of these were under review and development e.g. safeguarding. Following discussion with staff it was evident that they were familiar with the policies and procedures.

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. The registered manager advised of the procedures in place to ensure that incidents were shared with staff to prevent recurrence. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

The procedures to audit medicines management were reviewed. A variety of medicine audits were undertaken. These were completed daily by the staff and the registered manager. Running stock balances were maintained for all solid dosage medicines and inhaled medicines. This is good practice. An audit was also completed by the community pharmacist on a periodic basis. Management advised of the procedures in place to manage any identified areas for improvement.

Following discussion with the registered manager and care staff, it was evident that staff were familiar with their roles and responsibilities in relation to medicines management.

Staff confirmed that any medicines related concerns were raised with management. They advised that they were supported to do their work and that there were good working relationships within the home.

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

RQIA will phase out the issue of draft reports via paperlite in the near future. Registered providers should ensure that their services are opted in for the receipt of reports via Web Portal. If you require further information, please visit www.rqia.org.uk/webportal or contact the web portal team in RQIA on 028 9051 7500.

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