The Regulation and Quality Improvement Authority

Inspection Report

14 October 2021

Breffni Lodge

Type of service: Residential Care Home
Address: 3 Wandsworth Road, Belfast, BT4 3LS
Telephone number: 028 9065 3335

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Breffni Lodge **Responsible Individual:** Mr Mark John Uprichard	**Registered Manager:** Ms Regina Brady **Date registered:** 16 May 2013
Person in charge at the time of inspection: Ms Regina Brady	**Number of registered places:** 44
Categories of care: Residential Care (RC): DE – dementia I – old age not falling within any other category PH – physical disability other than sensory impairment	**Number of residents accommodated in the residential care home on the day of this inspection:** 29
Brief description of the accommodation/how the service operates: This is a residential care home which provides care for up to 44 residents.	

2.0 Inspection summary

An unannounced inspection took place on 14 October 2021 from 10.35am to 2.45pm. It was undertaken by a pharmacist inspector.

This inspection focused on medicines management within the home and also assessed progress with any areas for improvement identified since the last care inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines and residents were administered their medicines as prescribed.

There were systems in place to ensure that staff were trained and competent to manage medicines. No new areas for improvement were identified at this inspection.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection, information held by RQIA about this home was reviewed. This included previous inspection findings, incidents and correspondence. The inspection was completed by reviewing a sample of medicine related records and care plans, medicines storage and the auditing systems used to ensure the safe management of medicines. Residents' opinions were also obtained.

4.0 What people told us about the service

The inspector met with a small number of residents. Residents were relaxed and content in the home. They were complimentary about the staff, how well they were looked after and said they were happy in the home. No concerns were raised.

Staff interactions with residents were warm, friendly and supportive. It was evident they knew the residents well.

All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Feedback methods included a staff poster and paper questionnaires which were provided for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, one relative had completed and returned a questionnaire to RQIA. The response was positive indicating they were "very satisfied" with the care provided in the home.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last care inspection on 4 May 2021		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)		**Validation of compliance summary**
Area for Improvement 1 **Ref:** Standard 23.6 **Stated:** First time	The responsible person shall ensure that all staff induction records are signed and dated by each party to confirm that the induction has been fully completed.	**Carried forward to the next inspection**
	Action taken as confirmed during the inspection: There had been no new staff employed since the last inspection and validation of this area for improvement is carried forward to the next inspection.	
Area for improvement 2 **Ref:** Standard 25.3, 25.6 **Stated:** First time	The responsible person shall ensure that one person is designated as having responsibility for the whole home when the manager is not on duty and this is noted on the staff duty rota.	**Met**
	Action taken as confirmed during the inspection: The manager advised of the action taken and provided a copy of the duty rota, which clearly indicated who was in charge of the home each day, including when the manager was absent from the home.	
Area for improvement 3 **Ref:** Standard 27 **Stated:** First time	The responsible person shall ensure that mobility aids used by residents are kept clean and the cleanliness of residents' dining areas is maintained at all times.	**Carried forward to the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	

5.2 Inspection findings

5.2.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times the residents' needs will change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. These are records used to list all of the 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, for example at medication reviews and hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had verified and signed the personal medication records when they were written and updated, to check that they were accurate. The manager advised the current format of personal medication records was being reviewed, with plans to implement a new format in the near future.

Copies of residents' prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription. This is good practice.

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, modified diets, diabetes, warfarin, self-administration etc. Following a review of residents' files, there was evidence that detailed medicine related care plans were in place. The care plans were up to date and included the name of the medicine, details of recent medicine changes and were reviewed regularly.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the resident's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

The records inspected showed that medicines were available for administration when residents required them. Staff advised that they worked closely with each resident's GP and the community pharmacist to ensure that medicines are supplied in a timely manner.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each resident could be easily located. A controlled drugs cabinet and medicines refrigerator was in use in each treatment room.

Temperatures of the medicine refrigerator were monitored and recorded every day and these were within the recommended temperature range. Temperatures were being recorded on plain pages. It was agreed that the specific temperature record sheets would be put in place after the inspection.

There were systems in place to monitor and replace medicines which expire shortly after opening, such as eye drops.

Discontinued medicines were safely returned to the community pharmacy for disposal and records maintained.

5.2.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

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.

Review of a sample of the medicine administration records (MARs) evidenced that they had been well maintained and indicated that overall, residents had received their medicines as prescribed. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. Systems were in place to ensure that these records were filed appropriately each month.

Controlled drugs are medicines which are subject to strict legal controls, record keeping and legislation. They commonly include strong pain killers. A review of the controlled drugs records indicated that they had been well maintained and stocks were checked at each shift change.

The manager and staff audited medicine administration on a regular basis within the home. Several audits were carried out and included a variety of medicine formulations. Areas to improve on were shared with staff for their learning and followed up at supervision sessions with staff.

The date of opening was recorded on all medicines so that they could be easily audited and a running stock balance was maintained for most medicines. These are areas of good practice.

5.2.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

The management of medicines for new residents or residents discharged back to the home from hospital were reviewed. Written confirmation of the resident's medicine regime was received at or prior to admission and details updated on the resident's records. Details were updated on the personal medication records and MARs, by two staff. On a few occasions, the MARs entries were written by one staff member, but had not been checked by a second staff member. It was agreed that this would be discussed with staff.

Systems were in place to follow up on any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

5.2.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust auditing system will help to identify medicine related incidents.

The medicine related incidents reported to RQIA since the last medicines inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

With the exception of one medicine, the audits completed at the inspection showed that medicines were administered as prescribed. The manager agreed to follow up the identified discrepancy. Details of the findings and action taken were forwarded to RQIA after the inspection.

5.2.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported. Policies and procedures should be up to date and readily available for staff.

There were records in place to show that staff were trained and deemed competent in medicines management. Refresher training in medicines management was scheduled for staff.

6.0 Conclusion

The outcome of this inspection concluded that the residents were being administered their medicines as prescribed by their GP. One of the three areas for improvement identified at the last inspection was validated as met and two are carried forward for review at the next inspection.

Based on the inspection findings and discussions held we are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the manager with respect to medicines management.

7.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	2*

* The two areas for improvement are carried forward from the last inspection and will be reviewed at the next inspection.

This inspection resulted in no new 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.

Quality Improvement Plan

Action required to ensure compliance with Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref:** Standard 23.6 **Stated:** First time **To be completed by:** With immediate effect (4 May 2021)	The responsible person shall ensure that all staff induction records are signed and dated by each party to confirm that the induction has been fully completed. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Area for improvement 2 **Ref:** Standard 27 **Stated:** First time **To be completed by:** With immediate effect (4 May 2021)	The responsible person shall ensure that mobility aids used by residents are kept clean and the cleanliness of residents' dining areas is maintained at all times. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1

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