The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Silver Birch Lodge

Provider: Silverbirch Lodge Limited

Date of Inspection: 11 September 2025

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:	Silverbirch Lodge Limited
Responsible Individual:	Mrs Sandra Martha Phillips
Registered Manager:	Mrs Malgorzata Janusz, not registered
Service Profile: Silver Birch Lodge is a nursing home registered to provide nursing care for up to 33 patients. Patients' bedrooms are located over two floors. Patients have access to communal lounges, a dining room and garden.	

2.0 Inspection summary

An unannounced follow up inspection took place on 11 September 2025, from 10.30am to 2:40pm. The inspection was completed by a pharmacist inspector, and focused on medicines management within the home.

At the last medicines management inspection on 15 May 2025 safe systems were not in place for some aspects of medicines management. Areas for improvement were identified in relation to ensuring patients have a continuous supply of their prescribed medicines, record keeping for controlled drugs, the administration of inhaled medicines, the management of distressed reactions and insulin, and governance and audit. In addition, an area for improvement relating to informing RQIA of notifiable events was stated for a second time.

The findings of the last inspection were discussed with the responsible individuals and manager during a Serious Concerns meeting on 2 June 2025. Following this meeting, RQIA accepted the home's action plan to address the deficits and decided that a period of time would be given to implement the necessary improvements and that this follow up inspection would be undertaken to determine if the necessary improvements had been implemented and sustained.

Significant improvements in the management of medicines were observed. The medication auditing process had been reviewed to ensure that any shortfalls were identified and addressed; notifiable events were being reported to RQIA. Patients had a continuous supply of their prescribed medicines. Safe systems were in place for the management of distressed reactions, insulin and inhaled medicines. However, the area for improvement in relation to record keeping of controlled drugs was assessed as not met and has been stated for a second time.

Details of the inspection findings including the area for improvement stated for a second time can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients well.

RQIA would like to thank the staff for their assistance throughout the inspection.

3.0 The inspection

3.1 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

3.2 What people told us about the service and their quality of life

Staff said they had worked hard to implement and sustain improvements identified at the last medicines management inspection and had received help and support from senior management to do so. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each patient liked to take their medicines. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

RQIA did not receive any completed questionnaires or responses to the staff survey following the inspection.

3.3 Inspection findings

3.3.1 Management of distressed reactions

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Directions for use were clearly recorded on the personal medication record and patient-centred care plans were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. Records of administration included the reason for and outcome of each administration.

3.3.2 Management of insulin

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to insulin, care plans should include details on the actions to be taken if the patient's blood glucose levels is outside their recommended range.

The care plans in place when patients required insulin to manage their diabetes had been reviewed and updated. There was sufficient detail to direct staff if the patient's blood sugar was outside of the recommended range.

One in use insulin pen device was stored in the trolley with a sheathed needle attached. This was escalated to the manager for immediate action. Assurances were provided that all nurses would be made aware and that this practice would cease immediately.

3.3.3 Stock management

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient'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 procedures for ordering medicines had been reviewed and updated, staff were aware of the need to order medicines in a timely manner and to follow up any potential out of stocks. Records reviewed at this inspection evidenced that medicines were available for administration when patients required them.

3.3.4 Medicine administration

A sample of the medicines administration records was reviewed. The records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Staff had received training on the administration of inhaled medicines. The audits completed at the inspection indicated that inhaled medicines had been administered as prescribed.

3.3.5 Record keeping for controlled drugs

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book.

Since the last medicines management inspection a bound controlled drug record book has been in use. However the receipt and destruction of controlled drugs were not being recorded in the controlled drugs record book, rather the running balance was being updated to reflect the new total. Records of contolled drugs received into the home and disposed of must be accurately maintained in the controlled drug record book. An area for improvement was stated for a second time.

3.3.6 Governance and audit

The management team have implemented a robust audit tool, which covers all aspects of medicines management.

The audit was completed monthly by the manager and where shortfalls were identified there was evidence that these were discussed with the staff and addressed. The date of opening was recorded on medicines to facilitate audit and disposal at expiry. The audits completed at inspection indicated that medicines were administered as prescribed.

The need to include the standard of maintenance of the controlled drug record book in the audit process was discussed with staff and management.

3.3.7 Medicines related 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 audit system will help staff to identify medicine related incidents.

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

4.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been stated for a second time where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	1*	0

* the total number of areas for improvement includes one that has been stated for a second time

The area for improvement and details of the Quality Improvement Plan were discussed with Mrs Malgorzata Janusz, Manager and Mrs Sandra Phillips, Responsible Individual, as part of the inspection process. The timescale for completion commences from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** Second time	The registered person shall ensure that records for the receipt, administration and disposal of controlled drugs are maintained in a controlled drug record book. Ref: 3.3.5
To be completed by: 11 September 2025	**Response by registered person detailing the actions taken:** Administration and disposal of controlled drugs are maintained in a controlled drug record book as per RQIA . All nurses have been made aware to not draw any lines in the Controlled Administration book or Controlled Handover book. All Nursing staff are recording all controlled drugs received and totalled from chemist in the medication in the CD`s book All from above was completed from the last inspection on the 12.09.2025.

Please ensure this document is completed in full and returned via the Web Portal

The Regulation and Quality Improvement Authority

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