The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Braefield Court

Provider: Healthcare Ireland (Belfast) Limited

Date of Inspection: 29 August 2024

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:	Healthcare Ireland (Belfast) Limited
Responsible Person:	Ms Andrea Louise Campbell
Registered Manager:	Miss Jessica Sharp
Service Profile Braefield Court is a residential care home registered to provide health and social care for up to seven residents living with a learning disability. This home shares the same site as Braefield Nursing Home.	

2.0 Inspection summary

An unannounced inspection took place on 29 August 2024, from 10.50am to 3.05pm. This was completed by a pharmacist inspector and focused on medicines management within the home.

Review of medicines management found that improvements in some areas of the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan.

Whilst areas for improvement were identified, there was evidence that residents were being administered their medicines as prescribed.

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 residents, relatives, staff or the commissioning trust.

The inspection was completed by reviewing a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines, to evidence how the home is performing in relation to the regulations and standards. Discussions were held with staff and management about how they plan, deliver and monitor the management of medicines.

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

Throughout the inspection the RQIA inspector will seek to speak with residents, their relatives or visitors and staff to obtain their opinions on the quality of the care and support, their experiences of living, visiting or working in this home.

The inspector spoke with a range of staff on duty, including the manager.

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after residents and meet their needs. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

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, no questionnaires had been received by RQIA.

3.3 Inspection findings

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

Residents in residential care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times residents' needs may 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. For residents transitioning from hospital, their medicines were dispensed by the hospital pharmacy.

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 or hospital appointments.

The personal medication records reviewed were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records

when they were written and updated to confirm that they were accurate. A small number of discrepancies in external medicines were highlighted to staff for immediate corrective action and on-going vigilance, to ensure that these match the current prescription.

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

All residents should have care records 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 etc.

Residents will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care records 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 resident's distress and if the prescribed medicine is effective for the resident.

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Directions for use were clearly recorded and care records directing the use of these medicines were in place. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain and other factors. Records of administration included the reason for and usually the outcome of each administration. Staff were reminded to record the outcome of administration on every occasion.

The management of pain was discussed. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required.

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

Medicine 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.

Several expired medicines were available for use, including some medicines prescribed on a 'when required' basis, for the management of distressed reactions, which had been dispensed into a monitored dosage system. Robust systems must be in place to ensure that expired medicines are not available for administration. An area for improvement was identified.

Records reviewed showed that medicines were available for administration when residents required them. Staff advised that they had a good relationship with the pharmacist and that medicines were supplied in a timely manner.

Records of the receipt of medicines were maintained in a manner that resulted in some duplication and omissions. Additionally, medicines supplied in monitored dosage systems were not always individually receipted to ensure that each medicine and the strength, form and dose

were recorded. This was discussed and the management team agreed to review the format of these records. An area for improvement was identified.

The medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for the storage of controlled drugs.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. The current temperature of the medicine refrigerator was monitored each day; it was agreed that maximum and minimum temperatures would also be monitored and recorded on a daily basis.

Satisfactory arrangements were in place for the safe disposal of medicines. Staff were reminded that records of outgoing medicines should be checked and signed by two members of staff on all occasions.

3.3.3 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.

A sample of the medicines administration records was reviewed. Records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review. Some handwritten medicine administration records were in use. These had not been verified and signed by two members of staff, which is necessary to ensure accuracy. An area for improvement was identified.

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. There were satisfactory arrangements in place for the management of controlled drugs.

Occasionally, residents may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the resident's care records. Written consent and care records were in place when this practice occurred.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on most medicines; staff were reminded to record the date of opening on all medicines to facilitate audit.

3.3.4 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.

A review of records indicated that satisfactory arrangements were in place to manage medicines at the time of admission or for residents returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

3.3.5 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 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 registration 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.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

3.3.6 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 they staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

Records of staff training in relation to medicines management, epilepsy awareness, buccal midazolam were available for inspection.

It was agreed that the findings of this inspection would be discussed with staff to facilitate ongoing improvement.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	1*	9*

* the total number of areas for improvement includes seven which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Jessica Sharp, Registered Manager and Mr Adam Dickson, Regional Support Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 27 (4)(d)(i) **Stated:** First time **To be completed by:** With immediate effect (25 July 2024)	The registered person shall ensure that the identified fire door is either repaired or replaced to ensure the integrity of the premises fire compartmentation is maintained.
	The estates manager stated that the fire door could be closed and provided an update that a new door was ordered from a specialist provider and was due for delivery/fitting within a week. **Action required to ensure compliance with this regulation was not fully reviewed as part of this inspection and this is carried forward to the next inspection.**
Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022	
Area for improvement 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** Immediately and ongoing (29 August 2024)	The registered person shall ensure that robust systems are in place to dispose of expired medicines promptly. Ref: 3.3.2
	Response by registered person detailing the actions taken: Expiry dates on medication are audited during the managers monthly medication audit. Importance of this will be discussed in the next Team Leader meeting.
Area for improvement 2 **Ref:** Standard 31 **Stated:** First time **To be completed by:** Immediately and ongoing (29 August 2024)	The registered person shall ensure that robust systems are in place for the receipt of incoming medicines. Ref: 3.3.2
	Response by registered person detailing the actions taken: System in place for the receipt of incoming medicines will be reviewed monthly as part of magaerial governance. The importance of compliance with this system will discussed at the next Team Leader meeting.
Area for improvement 3 **Ref:** Standard 31 **Stated:** First time **To be completed by:** Immediately and ongoing (29 August 2024)	The registered person shall ensure that robust systems are in place for the management of handwritten medicine administration records, which should be verified and signed by two members of staff to ensure accuracy. Ref: 3.3.3
	Response by registered person detailing the actions taken: Full review into compliance in this area during monthly medication audits by the manager. Training to be provided in relation to the

	importance of compliance in this area during Team Leader meeting.
Area for improvement 4 **Ref:** Standard 25.6 **Stated:** First time **To be completed by:** 31 July 2024	The registered person shall ensure an accurate record is kept of the staff working over a 24-hour period and the capacity in which they work.
	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.
Area for improvement 5 **Ref:** Standard 6.6 **Stated:** First time **To be completed by:** 31 July 2024	The registered person shall ensure care records are signed and updated when a change occurs in the resident's care to ensure they continue to meet the resident's ongoing care needs. This is stated in reference to but not limited to nutrition, head injury and weight loss.
	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.
Area for improvement 6 **Ref:** Standard 12.12 **Stated:** First time **To be completed by:** 31 July 2024	The registered person shall ensure an accurate record is kept of all food and fluids consumed, including the amount, for those residents who require this.
	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.
Area for improvement 7 **Ref:** Standard 27 **Stated:** First time **To be completed by:** 31 July 2024	The registered person shall ensure the repairs identified at this inspection are completed in a timely manner.
	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.
Area for improvement 8 **Ref:** Standard 46 **Stated:** First time **To be completed by:** 25 July 2024	The registered person shall ensure staff adhere to infection prevention and control (IPC) best practice of being bare below the elbow.
	Action required to ensure compliance with this standard was not fully reviewed as part of this inspection and this is carried forward to the next inspection.

Area for improvement 9 **Ref:** Standard 20.10 **Stated:** First time	The registered person shall ensure that a robust system of audits is maintained to assure the quality of care and other services provided within the home and associated action plans are followed up. This includes, but is not limited to audits of: care records and skin care.
To be completed by: 25 July 2024	**Action required to ensure compliance with this standard was not fully reviewed as part of this inspection and this is carried forward to the next inspection.**

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews