Inspection Report

7 July 2022 & 14 July 2022

Lisnisky Residential Home

Type of service: Residential Care Home
Address: 16 Lisnisky Lane, Portadown, Craigavon, BT63 5RB
Telephone number: 028 3833 9153

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: Ann's Care Homes Limited **Responsible Individual:** Mrs Charmaine Hamilton	**Registered Manager:** Mrs Jolly Joseph **Date registered:** 9 May 2018
Person in charge at the time of inspection: Mrs Jolly Joseph	**Number of registered places:** 14
Categories of care: Residential Care (RC): I – old age not falling within any other category PH – physical disability other than sensory impairment MP(E) - mental disorder excluding learning disability or dementia – over 65 years LD(E) – learning disability – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 11
Brief description of the accommodation/how the service operates: Lisnisky Residential Home is a registered residential care home which provides health and social care for up to 14 residents. Each resident has their own bedroom. Residents have access to communal areas with secure outside spaces. There is a nursing home located in the same building. The registered manager manages both services.	

2.0 Inspection summary

An unannounced medicines management and finance inspection took place on 7 July 2022, from 10.20am to 1.25pm and on 14 July 2022 from 10.45am to 2.45pm. The inspection was completed by a pharmacist inspector and a finance inspector.

The inspection focused on medicines management and the management of residents' finances within the home and also assessed progress with the area for improvement identified at the last care inspection.

The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management and the management of residents' finances.

The outcome of the inspection in relation to medicines management concluded that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines. Medicines were stored safely and administered as prescribed. No areas for improvement were identified.

With regards to finance, adequate controls surrounding residents' finances were in place. Residents' financial records were up to date at the time of the inspection. No areas for improvement were identified.

RQIA would like to thank the residents and staff for their assistance throughout the 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 examining 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. A sample of residents' financial files which included records of transactions and residents' personal property were also reviewed.

Staff and residents views were obtained.

4.0 What people told us about the service

The inspectors met with one senior carer, the home administrator and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well. Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, five residents had completed and returned questionnaires. Their responses indicated they were very satisfied with all aspects of the care provided in Lisnisky Residential Home.

5.0 The inspection

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

Areas for improvement from the last inspection on 1 February 2022		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2021)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 6.2 **Stated:** First time	The registered person shall ensure that care plans accurately reflect the needs of the residents with particular reference to modified diet recommendations.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has now been met.	

5.2 Inspection findings

5.2.1 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.

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 at the inspection were accurate and up to date. In line with safe 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. Staff were reminded that obsolete personal medication records should be cancelled and archived to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the resident.

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 etc.

The management of pain was discussed. Staff advised that residents were able to communicate when they were in pain and that pain relief was administered when required. Two residents' records were reviewed. Each resident had a pain management care plan and their medicines had been administered as prescribed. One care plan was updated during the inspection to reflect a recent change in the strength of their prescribed medication.

Some residents may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the resident should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the resident.

Satisfactory systems were in place for the management of thickening agents. Speech and language recommendations and care plans were in place and correlated.

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 had a good relationship with the community pharmacist and that medicines were 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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately.

The medicine refrigerator and controlled drugs cabinet were being used appropriately.

Appropriate arrangements were in place for the disposal of medicines.

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.

A sample of the medicines administration records was reviewed; they were fully and accurately completed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The records of receipt and administration of controlled drugs were maintained to the required standard in a controlled drug record book. The date of disposal/transfer for a small number of controlled drugs had not been recorded and balances had not been brought to zero; this was discussed for corrective action and close monitoring.

Management and staff audited the management and administration of medicines on a monthly basis. In addition running stock balances were maintained for medicines which were not supplied in the monitored dosage system, including inhaled medicines. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

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

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new residents or residents returning from hospital. Written confirmation of the resident's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed and the medicines had been administered as prescribed.

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 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 learning shared with staff in order to prevent a recurrence.

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 they are supported. Policies and procedures should be up to date and readily available for staff.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

5.2.7 What arrangements are in place to ensure that residents' monies, valuables and personal property are appropriately managed and safeguarded?

A safe place was provided within the home for the retention of residents' monies and valuables. At the time of the inspection there were satisfactory controls around the physical location of the safe place and the members of staff with access to it. Records of residents' monies and valuables were up to date at the time of the inspection.

Bank accounts were in place to retain residents' personal monies and comfort fund monies, these are monies donated to the home for the benefit of all residents. A sample of statements from the bank accounts were reviewed, the accounts only contained residents' monies and were not used for the running of the care home.

A review of a sample of transactions from the comfort fund confirmed that records were up to date and that purchases from the fund were for the benefit of all residents.

A sample of records evidenced that reconciliations (checks) of monies and valuables held on behalf of residents were undertaken on a weekly basis. Reconciliations of the bank accounts were undertaken at the home's head office and by the home's administrator on a monthly basis. The records of the reconciliations were signed by the member of staff undertaking the reconciliation and countersigned by a senior member of staff.

Three residents' finance files were reviewed. Written agreements were retained in all three files. The agreements included the details of the current weekly fee paid by, or on behalf of, the residents and a list of services provided to residents as part of their weekly fee. A list of services available to residents at an additional cost, such as hairdressing, was also included within the agreements. The agreements were signed by the resident, or their representative, and a representative from the home. In line with good practice signed authorisation forms which provided details of the items members of staff were authorised to purchase, on behalf of residents, were also included in the agreements.

Review of records and discussion with staff confirmed that residents' weekly fees were paid to the home's head office by the Health and Social Care Trusts. Staff also confirmed that

residents were not paying an additional amount towards their fee over and above the amount agreed with the health and social care trusts.

Discussion with staff confirmed that no member of staff was the appointee for any resident, namely a person authorised by the Department for Communities to receive and manage the social security benefits on behalf of an individual.

A sample of purchases undertaken on behalf of residents was reviewed. The records were up to date at the time of the inspection. Two signatures were recorded against each entry in the residents' records and receipts were available from each of the purchases reviewed. A sample of records of payments to the hairdresser and podiatrist was also reviewed. These records were also up to date at the time of the inspection. The records were signed by the hairdresser and podiatrist and countersigned by a member of staff to confirm that the treatments took place.

A sample of records of resident's monies forwarded to the home from a Health and Social Care Trust was reviewed. The amounts recorded as received on behalf of the residents agreed to the records forwarded from the Trust.

A sample of two residents' files evidenced that property records were in place for both residents. The records were updated with additional items brought into residents' rooms and when items were disposed of. The records were checked and signed by two members of staff at least quarterly.

Policies and procedures for the management and control of residents' finances were available for inspection. The policies were readily available for staff use. The policies were up to date and reviewed at least every three years.

Discussion with staff confirmed that no transport scheme was in place at the time of the inspection.

No areas for improvement were identified during the finance inspection.

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Jolly Joseph, Registered Manager, as part of the inspection process and can be found in the main body of the report.

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