Inspection Report

4 May 2023

Lisnaree Care Home

Type of service: Residential Care Home
Address: c/o Bannview House Care Home, 23 Bannview Road, Banbridge, BT32 3RL
Tel No: 028 4066 0110

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 Individual:** Ms Amanda Mitchell	**Registered Manager:** Mrs Laura Sands **Date registered:** 6 January 2023
Person in charge at the time of inspection: Mrs Laura Sands	**Number of registered places:** 22
Categories of care: Residential Care (RC): I – old age not falling within any other category	**Number of residents accommodated in the residential care home on the day of this inspection:** 22
Brief description of the accommodation/how the service operates: Lisnaree is a registered residential care home which provides health and social care for up to 22 residents. Residents' bedrooms, the communal lounge and dining room are located on the ground floor. A nursing home which is under a separate registration, occupies the ground floor and first floor of the building and the registered manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 4 May 2023, from 10.15am to 1.00pm. This was completed by a pharmacist inspector and focused on medicines management within the home.

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.

The area for improvement identified at the last care inspection has been carried forward and will be followed up at the next care inspection.

Review of medicines management found that medicines were stored safely and securely. Medicine records were well maintained. There were effective auditing processes in place to ensure staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. One new area for improvement in relation to the management of medicines prescribed for distressed reactions was identified.

Whilst an area for improvement was identified, RQIA can conclude that overall the residents were being administered their medicines as prescribed.

RQIA would like to thank the 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. The inspector spoke with staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with the senior care assistant and the manager. 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.

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

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, one resident had completed and returned a questionnaire. Their responses indicated that they were very satisfied with all aspects of the care provided.

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 25 August 2022		
Action required to ensure compliance with Residential Care Homes Minimum Standards (2021)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 13.4 **Stated:** First time	The registered person shall ensure that the programme of activities is displayed in a suitable format and in an appropriate location so that residents and their representatives know what is scheduled.	**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 may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, the 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 mostly accurate and up to date. A small number of minor discrepancies were highlighted to the manager who gave an assurance that these would be rectified immediately. 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 state that they were accurate.

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.

Residents 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 on 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 for two residents. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain. However, a care plan was not in place for one resident reviewed and another care plan required updating to reflect the current prescribed medicine.

It was identified that in instances when these medicines were administered regularly, this had not been referred to the residents' GP for review. Records did not include the reason and outcome of each administration. An area for improvement was identified.

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. Care plans were in place and 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 had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines 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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the safe 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. The records were found to have been fully and accurately completed. Completed records were filed and readily retrievable for review.

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.

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 all medicines so that they could be easily audited. This is 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.

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.

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. There has been no medicine related incidents reported to RQIA. The audits completed at the inspection indicated that the medicines were being administered as prescribed.

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.

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.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with the Residential Care Homes Minimum Standards 2021.

	Regulations	Standards
Total number of Areas for Improvement	0	2*

* The total number of areas for improvement includes one that is carried forward for review at the next inspection.

The area for improvement and details of the Quality Improvement Plan were discussed with Mrs Laura Sands, Registered Manager, 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 Residential Care Homes Minimum Standards (August 2011) (Version 1:1)	
Area for improvement 1 **Ref:** Standard 13.4 **Stated:** First time **To be completed by:** Immediate action required (25 August 2022)	The registered person shall ensure that the programme of activities is displayed in a suitable format and in an appropriate location so that residents and their representatives know what is scheduled.
	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 6 **Stated:** First time **To be completed by:** Immediate and ongoing (4 May 2023)	The registered person shall review the management of medicines prescribed for distressed reactions to ensure that: • a care plan is in place to direct care • the reason for and outcome of administration is recorded • regular administration is referred to the residents' GP for review Ref: 5.2.1
	Response by registered person detailing the actions taken: Supervision has been completed with the Residential care staff with medication responsibilities with regard to PRN medication prescribed for distress reactions to ensure care plans are in place to ensure individualised direct care is provided. The PRN medication records have been reviewed. Supervision has been completed to ensure staff are recording the outcome/effectiveness of PRN medication prescribed and also within the daily progress notes. A review has taken place alongside the GP and review of the PRN medications prescribed and residents with regular PRN medication administration.

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The Regulation and Quality Improvement Authority

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