Inspection Report

11 January 2023

Innisfree

Type of service: Residential Care Home
Address: 110 Buckna Road, Broughshane, BT42 2NR
Telephone number: 028 2568 4497

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: Innisfree **Registered Person** Mrs Shauna Anne Stanford	**Registered Manager:** Mrs Shauna Anne Stanford **Date registered:** 1 April 2005
Person in charge at the time of inspection: Ms Molly Robinson, Senior Care Assistant, 9.30 am - 12.15pm Ms Emma Johnson, Supervisor, from 12.15pm - 2.00pm Mrs Shauna Anne Stanford, Manager, from 2.00pm	**Number of registered places:** 28 There shall be a maximum of five persons accommodated in care categories RC-LD, RC-PH and RC-PH (E). There shall be a maximum of 11 persons accommodated in care category RC-DE (mild to moderate dementia).
Categories of care: Residential Care (RC) I – Old age not falling within any other category DE – Dementia LD – Learning disability PH – Physical disability other than sensory impairment PH(E) - Physical disability other than sensory impairment – over 65 years	**Number of residents accommodated in the residential care home on the day of this inspection:** 23
Brief description of the accommodation/how the service operates: This home is a registered Residential Care Home which provides health and social care for up to 28 residents. The home is situated on the ground floor of the building with single bedrooms. Residents have access to two communal lounges, four bathrooms, the dining room and a patio and garden area.	

2.0 Inspection summary

An unannounced inspection took place on 11 January 2023, from 9.40 am to 4.30 pm by a care inspector and a pharmacy inspector.

The inspection assessed progress with all areas for improvement identified in the home during and since the last care and medicines management inspections and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Residents said that living in the home was a good experience. Residents unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Residents confirmed that they would have no issue with raising any concerns or complaints to staff. Specific comments received from residents are included in the main body of this report.

It was evident that staff promoted the dignity and well-being of residents; staff were observed chatting to the residents in a respectful and pleasant manner.

Review of medicines management found that satisfactory arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. One area for improvement was stated for a second time in relation to the secure storage of medicines, although it was acknowledged that progress had been made.

Two new areas requiring improvement were identified with regards to Dysphagia training and hand hygiene.

RQIA were assured that the delivery of care and service provided in Innisfree was safe, effective and compassionate and that the home was well led. Addressing the areas for improvement will further enhance the quality of care and services.

The findings of this report will provide the manager with the necessary information to improve staff practice and the residents' experience.

RQIA would like to thank the staff and residents 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 we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from residents, relatives, staff or the Commissioning Trust. The medicines management 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 also spoke to staff and management about how they plan, deliver and monitor the management of medicines in the home.

Throughout the inspection RQIA will seek to speak with residents, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Mrs Shauna Anne Stanford, manager, at the conclusion of the inspection.

4.0 What people told us about the service

Residents were positive in their comments about the care and staffing provided in Innisfree. Residents said “I am very content here, I have no complaints” and “this is a great place, I would recommend it to anyone”.

Staff spoke positively about working in the home. Staff spoken with said “I love it here, I am well supported, the team are great” and “yes I am very happy here, I am well supported by my manager and by my supervisor.”

A visiting professional said, “I have no concerns, the team here are very accommodating.”

No resident or relative questionnaires were returned following the inspection and there were no responses from the on-line staff survey.

A record of compliments received about the home was kept and shared with the staff team; this is good practice.

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 inspection on 27 January 2022		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (4)(a) **Stated:** First time	The registered person shall ensure any medicine which is kept in the home is stored in a secure place and administered safely to residents.	**Met**

	Action taken as confirmed during the inspection: All medicines were stored in the locked medicines storage area.	
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure the infection prevention and control issues identified in the report are addressed.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was met.	
Area for improvement 3 **Ref:** Regulation 14 (2)(a) **Stated:** First time	The registered person shall ensure all parts of the residential care home to which residents have access are free from hazards to their safety. This is in relation to the storage of cleaning chemicals.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was met.	
Area for improvement 4 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure all notifiable events are reported to RQIA without delay.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was met.	
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 25.3 **Stated:** First time	The registered person shall ensure that an up to date competency and capability assessment is completed for those staff taking charge of the residential home in the absence of the manager.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was met.	
Area for improvement 2 **Ref:** Standard 8.2 **Stated:** First time	The registered person shall ensure an accurate record is kept of the personal and support care provided to residents. This is in relation to recording the application of topical creams.	**Met**

	Action taken as confirmed during the inspection: This area for improvement was met.	
Area for improvement 3 **Ref:** Standard 6.6 **Stated:** First time	The registered person shall ensure care records are kept up to date and reflect the resident's current needs.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was met.	
Area for improvement 4 **Ref:** Standard 27 **Stated:** First time	The registered person shall ensure that the premises are well maintained and remain suitable for their purpose.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was met.	
Area for improvement 5 **Ref:** Standard 6 **Stated:** First time	The registered person shall ensure that medicine related care plans are up to date, reflect the resident's current needs and detail the prescribed care.	**Met**
	Action taken as confirmed during the inspection: Medicine related care plans were in place for the sample of residents' records examined. One exception was identified and the supervisor agreed to address this following the inspection. It was acknowledged that information on the care prescribed was available in the resident's record.	
Area for improvement 6 **Ref:** Standard 32 **Stated:** First time	The registered person shall ensure that the medicine trolley and cupboards are attached to the wall to ensure security and safety.	**Partially met**
	Action taken as confirmed during the inspection: The medicine trolley and cupboards had been relocated to a suitable locked storage room. The trolley and cupboards must be secured to the wall, this was not in place and advice was provided. **This area for improvement was stated for a second time.**	

Area for improvement 7 **Ref:** Standard 33 **Stated:** First time	The registered person shall ensure that systems are in place to closely monitor critical medicines and detail the reason for any omission.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this had been satisfactorily addressed; critical medicines were available for and had been administered as prescribed.	
Area for improvement 8 **Ref:** Standard 31 **Stated:** First time	The registered person shall ensure that records used to record the reason for and outcome of the use, and the running balance for medicines used on a 'when required' basis for pain relief and distressed reactions, are updated on every occasion these medicines are administered.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this had been satisfactorily addressed. The records for the 'when required' medicines examined, had been completed appropriately.	
Area for improvement 9 **Ref:** Standard 31 **Stated:** First time	The registered person shall ensure that written confirmation is held of medicines for residents new to the home or for changes to prescribed regimes.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this had been satisfactorily addressed. Written confirmation of medicines prescribed and changes to prescribed regimes were in place in the records examined.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. Robust pre-employment checks are required to ensure that residents are protected as far as possible. In one file checked, it was difficult to ascertain if gaps in employment had been explored.

This was discussed with the manager who provided written evidence that this had been fully addressed. An area for improvement was therefore not identified at this time.

The manager had a system in place to monitor staff's professional registration with the Northern Ireland Social Care Council (NISCC).

It is important that staff are provided with mandatory and other training relevant to their roles in the home. There were systems in place to ensure that staff were trained and supported to do their job. Staff demonstrated good knowledge of their roles and responsibilities regarding Adult Safeguarding and Deprivation of Liberty Safeguards (DoLS). Staff demonstrated good knowledge of modified diets and of SALT assessments within the home; however, no formal Dysphagia training has taken place. This was discussed with the manager for action and an area for improvement was identified.

Residents told us that the staff were "very nice" and "the staff are excellent, I am very happy here".

Staff knew the residents well and knew how to respond to the different assessed needs and wishes of each individual resident.

It was noted that there was enough staff in the home to respond to the needs of the residents in a timely way; and to provide residents with a choice on how they wished to spend their day. For example, staff were observed responding to call bells promptly in a caring and compassionate manner. Staff were also observed spending time with residents chatting with then in the lounge.

Staff said there was good team work and that they felt well supported in their role, were satisfied with the staffing levels, training arrangements and the level of communication between staff and management. One new member of staff told us that her induction had been detailed and that she had been well supported throughout the induction period.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty. The duty rota did not have the full names of the staff on duty. This was highlighted to the manager for immediate action and review.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the residents. Observation of practice, review of care records and discussion with staff and residents established that staff were knowledgeable of individual residents' needs, their daily routine, wishes and preferences.

Staff were observed interacting with residents in a respectful and compassionate manner. Staff were skilled in communicating with residents; they were understanding and sensitive to residents' needs. Staff were observed to be prompt in responding to call bells throughout the day.

It was observed that staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly.

At times some residents may be required to use equipment that can be considered to be restrictive; for example, bed rails and alarm mats. It was established that safe systems were in place to manage this aspect of care.

Where a resident was at risk of falling, measures to reduce this risk were put in place. Examination of records and discussion with the manager confirmed that the risk of falling and falls were well managed. There was evidence of updated falls risk assessments and appropriate onward referral as a result of the post falls review. There was evidence of a monthly falls audit being carried out by the manager. One resident told us "I fell recently and the staff were very quick to come to me and help me out, they looked after me well."

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff.

There was evidence that residents' needs in relation to nutrition were being met. Staff told us how they were made aware of residents' nutritional needs and confirmed that residents care records are reviewed to ensure residents received the correct consistency of diet. An examination of records confirmed that SALT assessments were in place where required.

The dining experience was a relaxed and sociable experience; residents were seen to be chatting with staff and each other throughout the meal. The food smelled appetising and portions were generous. The menu for the day was on display and both residents and staff confirmed that choices for meals were always offered.

Residents' needs were assessed at the time of their admission to the home. Following the initial assessment person centred care plans were developed were developed to support staff to meet the individual needs of each resident. These care records were well maintained and regularly evaluated to ensure they continued to meet the residents' needs. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate. All care records were held confidentially.

Daily records were kept of how each resident spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded. Any concerns raised by staff with regards to residents were recorded and addressed in a timely manner.

There was evidence that residents' weights were checked at least monthly to monitor weight loss or gain.

There was evidence that each resident had an annual review of their care.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was clean, tidy and well maintained. Residents' bedrooms were personalised with photographs and other items or memorabilia. Bedrooms and communal areas were well decorated, suitably furnished, and comfortable. One resident commented "they look after the place well, it is cleaned every day."

Residents could choose where to sit or where to take their meals and staff were observed supporting residents to make these choices throughout the day.

Fire safety measures were in place and well managed to ensure residents, staff and visitors to the home were safe. The latest fire risk assessment was carried out on 14 January 2022, this resulted in no actions. Staff were aware of their training in this area and how to respond to any concerns or risks.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, there was ample supply of Personal Protective Equipment (PPE) within the home.

Staff were observed using PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept. However; on the day of the inspection, staff did not take the opportunity to demonstrate hand hygiene measures at the appropriate times, for example, after the lunch time meal staff did not take the opportunity to use hand hygiene measures after contact with each resident. This was discussed with the manager for immediate action and an area for improvement was identified.

5.2.4 Quality of Life for Residents

Discussion with residents confirmed that they were able to choose how they spent their day. For example, residents could have a lie in or stay up late to watch TV. It was observed that staff offered choices to residents throughout the day which included food and drink options, and where and how they wished to spend their time.

There were lovely views of Slemish and the surrounding countryside from the lounge and garden for residents to enjoy, and one resident told us “in the better weather I go out for walks, it is lovely here.”

Staff discussed the importance of a person centred approach when it came to activities for the residents. An activities planner was made available to the residents and was on display in both lounges. Activities on this planner included; arts and crafts sessions, board games and exercises. A review of the activities folder showed that activities were well attended by the residents.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Residents told us the staff assisted them to keep in touch with their families through phone calls and visits to the home.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Shauna Anne Stanford has been the manager of Innisfree since 1 April 2005.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to residents. There was evidence of auditing across various aspects of care and services provided by the home.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home’s safeguarding policy. The manager was identified as the appointed safeguarding champion for the home.

It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults. Staff presented as knowledgeable with regards to the safeguarding process and a review of the training records confirmed that staff had completed their mandatory safeguarding training.

Staff commented positively about the manager and described her as supportive, approachable and always available for guidance. Staff said the manager encouraged learning and provided good leadership.

There was evidence that the manager ensured that complaints were managed correctly and that good records were maintained. Residents spoken with said that they knew how to report any concerns and said they were confident that the manager would take any concerns seriously and deal with them appropriately. One resident told us "all my queries are answered quickly."

Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about residents, care practices or the environment.

It was established that the manager had put in place a robust system to monitor accidents and incident that happened in the home. Accidents and incidents were notified, if required, to residents' next of kin, their care manager and to RQIA.

The home was visited each month by the registered provider to consult with residents, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by residents, their representatives, the Trust and RQIA.

5.2.6 Medicines Management

Personal medication records and care plans

Residents 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 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 accurate and up to date. In line with safe practice, a second member of staff had checked and signed the majority of the personal medication records when they were written and updated to state that they were accurate. It was agreed that staff would be reminded that this should take place on every occasion.

Copies of 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 etc.

In the sample of records examined, relevant care plans/information were in place (See Section 5.1). Advice was provided on the resident specific detail that should be included.

Medicine supply and storage

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that each resident's medicines are available for administration as prescribed.

It is important that medicines 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. The trolley and cupboards should be secured to the wall as discussed in Section 5.2. An area for improvement was stated for a second time.

Storage areas were tidy and organised so that medicines belonging to each resident could be easily located. A medicine refrigerator and controlled drugs cabinet were available for use as needed. The temperature of the medicine storage area should be monitored and recorded daily to ensure that medicines are stored appropriately at temperatures not exceeding 25^{o}C. 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. Only the current temperature of the medicine refrigerator was monitored each day; this does not provide evidence that the temperature was maintained within the required range at all times. Advice was provided and it was agreed that this would be implemented following the inspection.

Satisfactory arrangements were in place for the disposal of medicines. Staff were reminded that the date, reason for disposal/transfer and the signature of the second staff member should be recorded on every occasion.

Medicine administration

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 medication administration records was reviewed. The records had been completed in a satisfactory manner. There was evidence that medicines were available for administration as prescribed.

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 a controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs, however staff were reminded to include the name, form and strength of the controlled drug at the top of each page.

Governance and audit

Management and staff audited medicine administration on a regular basis within the home. The audits completed at the inspection indicated that medicines were administered as prescribed. The date of opening was recorded on medicines so that they could be easily audited. This is good practice.

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.

The management of medicines on admission and medication changes

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 residents new to the home or returning from hospital.

Staff training and competency assessment

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.

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

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and/or the Residential Care Homes' Minimum Standards (August 2011) (Version 1:1).

	Regulations	Standards
Total number of Areas for Improvement	0	3*

* The total number of areas for improvement includes one standard in relation to medicines management that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Shauna Anne Stanford, registered 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 32 **Stated:** Second time	The registered person shall ensure that the medicine trolley and cupboards are attached to the wall to ensure security and safety. Ref: 5.1
To be completed by: 25 January 2023	**Response by registered person detailing the actions taken:** The medicine trollies are now attached to the wall and located inside a locked room. The cupboards are no longer needed and any overtsock medication is locked in overtstock cupboard.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)	
Area for improvement 1 **Ref:** Standard 23.4 **Stated:** First time	The registered person shall ensure that all staff receive dysphagia training, in line with their roles and responsibilities. Ref: 5.2.1
To be completed by: 31 May 2023	**Response by registered person detailing the actions taken:** All staff have received dysphagia training in line with their roles and responsibilities.
Area for improvement 2 **Ref:** Standard 35.7 **Stated:** First time	The registered person shall ensure that all staff are aware of the importance of hand hygiene and that staff carry out effective hand hygiene measures at the appropriate times. Ref: 5.2.3

To be completed by: From the date of inspection	
	Response by registered person detailing the actions taken: All staff have been reminded of the importance of carring out hand hygiene measures at appropriate times.

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

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