The Regulation and Quality Improvement Authority

Inspection Report

11 January 2022

Innisfree

Type of service: Residential Care Home
Address: 110 Buckna Road, Broughshane, BT42 4NR
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 **Responsible Individual:** Mrs Shauna Anne Stanford	**Registered Manager:** Mrs Shauna Anne Stanford **Date registered:** 1 April 2005
Person in charge at the time of inspection: Ms Emma Johnson, Supervisor	**Number of registered places:** 28 Including: - a maximum of five residents in categories RC-LD, RC-PH and RC-PH(E) - a maximum of 11 residents in category RC-DE (mild to moderate dementia).
Categories of care: Residential Care (RC): I – old age not falling within any other category DE – dementia PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years LD – learning disability	**Number of residents accommodated in the residential care home on the day of this inspection:** 24
Brief description of the accommodation/how the service operates: This is a residential care home registered to provide care for up to 28 residents.	

2.0 Inspection summary

An unannounced inspection took place on 11 January 2022, from 10.30am to 2.15pm. The inspection was conducted by a pharmacist inspector.

This inspection focused on medicines management within the home and also assessed progress with the area for improvement identified at the last care inspection. The purpose 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 outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan and include the administration of antibiotics, medicine related care plans,

the secure storage of medicines and the verification of medicines on admission and when doses are changed. The area for improvement identified at the last care inspection was assessed as having been met

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

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 reviewing a sample of medicine related records and care plans, medicines storage and the auditing systems used to ensure the safe management of medicines. Discussions were held with staff about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

To reduce footfall throughout the home, the inspector did not meet with any residents, although they were observed to be relaxed and content in the home.

The inspector met with the supervisor in charge. Staff were warm and friendly and it was evident from discussions that they knew the residents well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was supportive of staff and 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.

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 12 December 2020		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 19 (3) (b) **Stated:** First time	The registered person shall ensure that records are at all times available for inspection in the home by any person authorised by RQIA to enter and inspect the home.	**Met**
	Action taken as confirmed during the inspection: All records requested were available for 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 will 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 and hospital appointments.

The personal medication records reviewed at the inspection were accurate and up to date. Most of the records had been signed and checked by two staff to ensure that they were accurate. Staff were reminded that this should occur on each occasion, when records are written and updated.

Copies of new prescriptions and hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the resident's prescription. This is safe 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, warfarin, self-administration etc. Following a review of residents' files, there was evidence that medicine related care plans were mostly in place and up to date. However, some care plans needed updating to reflect current instructions and provide sufficient detail to direct the prescribed care, for example, the management of warfarin, diabetes and distressed reactions. This was discussed and advice was provided. An area for improvement was identified.

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 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 worked closely with each resident's GP and the community pharmacist to ensure that medicines were supplied in a timely manner.

The medicines trolley and cupboards were observed to be locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each resident could be easily located. The medicine trolley and two small medicine cupboards were located in the dining room. However, they were not attached to the wall and there was no means of attachment in place; this is necessary for the security and safety of medicines. This was highlighted at the last medicines management inspection with regards to the medicine trolley. An area for improvement was identified.

A medicine refrigerator and controlled drugs cabinet were available for use as needed. Temperatures of the medicine refrigerator were monitored and recorded and these were within the recommended temperature range. It was agreed that the temperature of the medicines storage area would also be monitored and recorded on a daily basis.

Discontinued medicines were returned to the community pharmacy for disposal and records maintained. Staff were reminded that the date and reason for disposal should be recorded on every occasion as is the expected practice in the home.

It was advised and agreed that with immediate effect, inhaler administration devices would be marked with the resident's name and stored covered for infection and control purposes.

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.

Review of a sample of the medicine administration records (MARs) evidenced that they had been well maintained and indicated that overall, residents had received their medicines as prescribed. However, audits completed indicated that there were gaps in the administration of two antibiotics indicating the residents had missed a small number of doses. The importance of these critical medicines was discussed and an area for improvement was identified.

Separate administration records were in use 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. This was acknowledged as good practice, however there were gaps in these records. Staff should update these on every occasion these medicines are administered. An area for improvement was identified.

Controlled drugs are medicines which are subject to strict legal controls, record keeping and legislation. They commonly include strong pain killers. A review of the controlled drugs records indicated that they had been well maintained and stocks checks were performed on controlled drugs which require safe custody at each shift change. It was advised that checks should be performed on other controlled drugs as part of the audit process.

The date of opening was recorded on the majority of medicines so that they could be easily audited.

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 residents returning from hospital.

Written confirmation of the resident's medicine regime had not always been obtained at admission for residents new to the home or for changes to prescribed regimes for warfarin, although these had all been confirmed by telephone with the prescriber. It is considered best practice to receive written confirmation to verify accuracy and for reference if necessary. An area for improvement was identified.

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.

The audit system in place helps staff to identify most medicine related incidents. 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.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. It was agreed that the areas for improvement identified during this inspection would be included within audit processes to drive sustained improvement.

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 that staff are supported.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review of competency was monitored through supervision sessions with staff and at annual appraisal. It was agreed that the areas highlighted for attention and identified for improvement at this inspection would be discussed with staff.

Medicines management policies and procedures were in place and had been reviewed every two years.

It was agreed that the list of sample signatures and initials for those staff authorised to administer medicines would be updated to reflect current staffing arrangements.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Residential Care Homes Minimum Standards, August 2021.

	Regulations	Standards
Total number of Areas for Improvement	0	5

Areas for improvement and details of the Quality Improvement Plan were discussed with

Ms Emma Johnson, Supervisor, 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 Minimum Standards, August 2021	
Area for improvement 1 **Ref:** Standard 6 **Stated:** First time **To be completed by:** 18 January 2022	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. Ref: 5.2.1 **Response by registered person detailing the actions taken**: Medicine related care plans have been updated to reflect current needs and precribed care.
Area for improvement 2 **Ref:** Standard 32 **Stated:** First time **To be completed by:** 18 January 2022	The registered person shall ensure that the medicine trolley and cupboards are attached to the wall to ensure security and safety. Ref: 5.2.2 **Response by registered person detailing the actions taken**: The medicine trolley and cupboards are now locked in a large cupboard and the medication is dispensed from this location.
Area for improvement 3 **Ref:** Standard 33 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that systems are in place to closely monitor critical medicines and detail the reason for any omission. Ref: 5.2.3 **Response by registered person detailing the actions taken**: The correct quantity of critical medicines have been requested from the GP to ensure apropriate stocks of critical medicines are available.
Area for improvement 4 **Ref:** Standard 31 **Stated:** First time **To be completed by:** Immediate and ongoing	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. Ref: 5.2.3

	Response by registered person detailing the actions taken: This wil be incorporated into the medicine audit so registered person can ensure when medicines are used 'when required' and for distressed actions records are updated on every occasion.
Area for improvement 5 **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. Ref: 5.2.4
To be completed by: Immediate and ongoing	**Response by registered person detailing the actions taken**: The registered person shall ensure written confirmation is received for changes to prescribed regimes or for new residents being admitted to the home.

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews