Inspection Report

19 July 2021

Lisnisky Care Home

Type of service: Nursing 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 Ltd **Responsible Individual:** Mrs Charmaine Hamilton	**Registered Manager:** Mrs Jolly Joseph **Date registered:** 17 April 2018
Person in charge at the time of inspection: Mrs Jolly Joseph	**Number of registered places:** 56 This number includes a maximum of 14 patients in category NH-DE. The home is approved to provide care on a day basis only for nine persons.
Categories of care: Nursing care (NH): I – old age not falling within any other category DE – dementia TI – terminally ill	**Number of residents accommodated in the residential care home on the day of this inspection:** 42
Brief description of the accommodation/how the service operates: This is a registered nursing home which provides nursing care for up to 56 persons.	

2.0 Inspection summary

An unannounced inspection took place on 19 July 2021 between 10.20am and 3.45pm. The inspection was carried out by a pharmacist inspector.

This inspection focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified since the last care 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.

To complete the inspection 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 were reviewed.

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept

4.0 What people told us about the service

We met with three nurses and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff were warm and friendly and it was evident from their interactions that they knew the patients well. Patients were observed to be relaxing in the foyer and lounges.

Nurses expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after patients and meet their needs. They spoke highly of the support given by management.

In order to reduce footfall throughout the home, the inspector did not meet with any patients. Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report no responses had been received.

5.0 The inspection

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

No areas for improvement were identified at the last medicines management inspection on 13 December 2017. The last inspection to the nursing home was undertaken on 24 May 2021 by a care inspector.

Areas for improvement from the last inspection on 24 May 2021		
Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 27 (4) (d) (i) **Stated:** First time	The registered person shall ensure that doors leading to bedrooms in the home are not prevented from closing in the event of a fire alarm sounding.	**Met**
	Action taken as confirmed during the inspection: The inspector observed doors leading to bedrooms were not prevented from closing in the event of a fire. Bedroom doors were not propped open with door stoppers.	
Action required to ensure compliance with The Care Standards for Nursing Homes, April 2015.		**Validation of compliance summary**
Area for improvement 1 **Ref:** Standard 46 Criteria (2) **Stated:** First time	The registered person shall ensure that actions are taken to prevent cross contamination between clothing for cleaning and laundered clothing within the laundry room.	**Met**
	A Perspex screen has been erected in order to separate unclean clothing from laundered clothing.	
Area for improvement 2 **Ref:** Standard 4 Criteria (9) **Stated:** First time	The registered person shall ensure that care records such as reposition charts or fluid intake charts are monitored to ensure that these have been completed and/or timely action is taken when an issue is identified.	**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?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs will 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.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. 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 majority of the personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had checked and signed the personal medication records when they are written and updated to provide a double check that they were accurate. A small number of recent changes to patients' medication regimes had not been recorded on the personal medication records. These were discussed with the nurses on duty for immediate corrective action. Nurses were reminded that obsolete personal medication records should be cancelled and archived and that where more than one record is in place they should be labelled 1 of 2, 2 of 2 etc.

All patients 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, self-administration etc.

Patients 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 nurses record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed for several patients. Nurses knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Care plans directing the use of these medicines were in place and directions for use were clearly recorded on the personal medication records. The reason for and outcome of administration were recorded.

These medicines were administered regularly to some patients. Nurses advised that the identified patients could request the medicines and that their GPs were aware of the regular use. It was agreed that the care plans would be updated to reflect this.

The management of pain was reviewed. Nurses advised that they were familiar with how each patient expressed their pain. Care plans were in place to direct nurses and there was evidence that pain relief was administered as prescribed.

Some patients 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 patient 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 patients.

The management of thickening agents and nutritional supplements was reviewed for five patients. Speech and language assessment reports and up to date care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained in the dementia care unit. However, in the general nursing unit care assistants were not recording the administration of thickening agents. An area for improvement was identified.

A small number of patients have their medicines administered in food/drinks to assist administration. Authorisation had been received from the prescriber and care plans were in place. It was agreed that the care plans would be updated to include more information on how the medicines were safely administered.

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 patient'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.

With the exception of a small number of medicines (See Section 5.2.4), records inspected showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

A review of the daily medicines refrigerator temperature records showed that the minimum/ maximum temperatures were consistently 5^{o}C and 10^{o}C in the dementia care unit. This indicates that the thermometer was not reset each day after the temperatures were checked. The thermometer was reset at the inspection and appropriate temperatures were observed. It was agreed that nurses would receive supervision on monitoring the refrigerator temperature and that this would be monitored through the audit process.

Satisfactory systems 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 patients to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. The sample of these records reviewed were found to have been fully and accurately maintained. The records were filed once completed and were readily retrievable for audit/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 are recorded in a controlled drug record book. Records for controlled drugs were maintained to the required standard.

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. One audit discrepancy in the administration of an inhaled medicine was observed. This was brought to the attention of the manager and nurses who advised that the patient had difficulty using the inhaler and that it was under review by the GP.

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.

The management of medicines on admission to the home was reviewed for two patients. Written confirmation of the medication regimens had been received. Two nurses had verified and signed the personal medication records and medication administration records to ensure accuracy of transcribing. Medicines had been accurately received into the home and administered in accordance with the most recent directions. However, a small number of missed doses were observed for “when required” laxatives and nutritional supplements as they had not been available for administration. The manager was aware of the out of stocks and nurses had been liaising with GP practices, dietician and the patients’ families to resolve the issues. Nurses were aware that medicines must be available for administration and had taken appropriate action.

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 medicine related incidents. Management and staff were familiar with the type of incidents that should be reported.

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 patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported. Policies and procedures should be up to date and readily available for staff.

Update training on medicines management and competency assessments were completed annually. Records were available for inspection.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

Although one area for improvement in relation to records for the administration of thickening agents was identified, RQIA is assured that, with the exception of a small number of medicines, the patients were administered their medicines as prescribed.

We would like to thank the patients and staff for their assistance throughout the inspection.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes, April 2015.

	Regulations	Standards
Total number of Areas for Improvement	1	1*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Jolly Joseph, 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection onwards	The registered person shall ensure that accurate records for the administration of thickening agents are maintained. Ref: 5.2.1
	Response by registered person detailing the actions taken: Registered Manager has completed a full review of records of the administration of thickening agents and fluid intake charts. A monitoring system put in place for the registered Nurses to check those supplementary charts on each shift. Registered Manager will be monitored the same.
Action required to ensure compliance with The Care Standards for Nursing Homes, April 2015.	
Area for improvement 1 **Ref:** Standard 4 Criteria (9) **Stated:** First time **To be completed by:** 24 June 2021	The registered person shall ensure that care records such as reposition charts or fluid intake charts are monitored to ensure that these have been completed and/or timely action is taken when an issue is identified.
	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

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