The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Lisgarel (Residential Care Home)

Provider: Northern Health and Social Care Trust

Date of Inspection: 3 October 2024

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:	Northern Health and Social Care Trust
Responsible Person:	Ms Jennifer Welsh
Registered Manager:	Mrs Louanne Bakker, not registered
Service Profile Lisgarel is a residential care home registered to provide health and social care for up to 40 residents. This includes some residents receiving a period of respite care and some residents recently discharged from hospital receiving care prior to discharge to their own homes.	

2.0 Inspection summary

An unannounced inspection took place on 3 October 2024, from 10.00am to 2.00pm. This was completed by two pharmacist inspectors and focused on medicines management within the home.

Review of medicines management identified two areas for improvement, these are detailed in the quality improvement plan and include, records for medicines prescribed for administration 'when required' for the management of distressed reactions and cancelling/archiving obsolete personal medication records promptly.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, residents were being administered their medicines as prescribed.

RQIA would like to thank the staff for their assistance throughout the inspection.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from residents, relatives, staff or the commissioning trust.

The inspection was completed by reviewing 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, to evidence how the home is performing in relation to the regulations and standards. Discussions were held with staff and management about how they plan, deliver and monitor the management of medicines.

3.2 What people told us about the service and their quality of life

Throughout the inspection the RQIA inspector will seek to speak with residents, their relatives or visitors and staff to obtain their opinions on the quality of the care and support, their experiences of living, visiting or working in this home.

The inspectors spoke with staff and management to seek their views of working in the home.

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after residents and meet their needs. They said that the team communicated well and the management team were readily 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, ten questionnaires had been received by RQIA with positive responses regarding the management of medicines.

3.3 Inspection findings

3.3.1 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 were accurate and up to date. 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 confirm that they were accurate.

Obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly. An area for improvement was identified.

Copies of residents' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription. This is good practice.

All residents should have care records 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.

Residents will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care records are in place to direct staff 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. Directions for use were clearly recorded and care records directing the use of these medicines were in place. Staff knew how to recognise a change in a resident's behaviour and were aware that this change may be associated with pain and other factors. Records of administration did not routinely include the reason for 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 records were in place and reviewed regularly.

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 records 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.

The management of thickening agents and nutritional supplements were reviewed. Speech and language assessment reports and care records were in place. Records of prescribing and administration were maintained. One personal medication record and care plan did not include the recommended consistency level and this was addressed immediately. The correct consistency was being administered.

3.3.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine 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.

Records reviewed 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 medicine 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 medicines storage area was monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

Satisfactory arrangements were in place for the safe disposal of medicines.

3.3.3 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. Records were found to have been accurately completed. 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 should be recorded in the controlled drug record book. There were mostly satisfactory arrangements in place for the management of controlled drugs and records were accurately maintained. It was agreed that an appropriate pre-printed controlled drugs record book, with numbered pages, would be obtained for use going forward.

Management and staff completed a number of medicine audits on a weekly basis within the home. The date of opening was recorded on medicines so that they could be easily audited. This is good practice. The use of a comprehensive audit tool which covers all aspects of the management of medicines was advised and discussed with staff.

3.3.4 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 at the time of admission or for residents returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

3.3.5 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 the 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. However, audit discrepancies were observed in the administration of a small number of medicines including inhalers. The audits were discussed in detail with staff for on-going vigilance.

3.3.6 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 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 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.

It was agreed that the findings of this inspection would be discussed with staff to facilitate ongoing improvement.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	3*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Margaret Montgomery, Senior Care Assistant, 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, December 2022	
Area for improvement 1 **Ref:** Standard 31 **Stated:** First time **To be completed by:** From the date of inspection 3 October 2024	The registered person shall ensure that obsolete personal medication records are cancelled and archived promptly. Ref: 3.3.1
	Response by registered person detailing the actions taken: Obsolate personal medication records have been cancelled and archived.
Area for improvement 2 **Ref:** Standard 10 **Stated:** First time **To be completed by:** From the date of inspection 3 October 2024	The registered person shall ensure that the reason for and the outcome of the administration, are recorded for medicines prescribed on a 'when required' basis for the management of distressed reactions. Ref: 3.3.1
	Response by registered person detailing the actions taken: Staff are aware of the need to record the reason for using 'When Required' medication Staff are aware of the need to record how the service user has reacted following the administration of the medication. Staff are aware that doing so will help to identify common triggers which may cause distress and if the prescribed medicine is effective.

Area for improvement 3 **Ref:** Standard 19 **Stated:** First time **To be completed by:** From the date of inspection 5 September 2023	The registered person shall ensure that the pre-employment checklist held in the home contains confirmation that the following has been completed; • evidence of references, one of which must be from most recent employer • evidence that gaps in employment have been discussed • evidence of reason for leaving last employment • evidence that a relevant access NI check has been completed.
	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.

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

The Regulation and Quality Improvement Authority

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