

# Inspection Report

**Name of Service:** Lisnisky Care Home

**Provider:** Ann's Care Homes

**Date of Inspection:** 4 November 2024

Information on legislation and standards underpinning inspections can be found on our website <https://www.rqia.org.uk/>

## 1.0 Service information

<b>Organisation:</b>	Ann's Care Homes
<b>Responsible Individual:</b>	Mrs Charmaine Hamilton
<b>Registered Manager:</b>	Ms Sherly Mathai
<p><b>Service Profile:</b> Lisnisky Care Home is a nursing home registered to provide nursing care for up to 56 patients. General nursing is provided on the Brownlow wing, Donard wing and Gardiner wing which are located on ground level. Dementia nursing is provided on the lower ground wing. Patients have access to communal lounges, dining rooms and a garden.</p> <p>This home shares the same building as Lisnisky Residential Home. The registered manager is responsible for both services.</p>	

## 2.0 Inspection summary

An unannounced inspection took place on 4 November 2024, from 10.10am to 15.00pm. This was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care records were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. No new areas for improvement were identified.

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients well.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

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 patients, relatives, staff or the commissioning trust.

Throughout the inspection the RQIA inspector will seek to speak with patients, 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.

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

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients 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.

RQIA did not receive any completed questionnaires or responses to the staff survey following the inspection.

#### **3.3 Inspection findings**

##### **3.3.1 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 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.

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 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.

Copies of patients' 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 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 etc.

The management of distressed reactions, pain, insulin and warfarin were reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed at the inspection indicated that these medicines were 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 patient.

The management of thickening agents and nutritional supplements was reviewed. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained. The care plan for one patient hadn't been updated with the most recently prescribed consistency. This was highlighted to staff for correction and ongoing vigilance.

### **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 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.

Records reviewed 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.

The medicine storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Temperatures of medicine storage areas were 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 patients 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 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 satisfactory arrangements in place for the management of controlled drugs.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits had been discussed with staff and addressed/ action plans had been implemented and addressed. The date of opening was recorded on medicines to facilitate audit and disposal at expiry.

### **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 patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. For one new admission, written confirmation was not available to review at the time of inspection however the deputy manager and nursing staff confirmed they had received the patients' medicine list from the GP practice. 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 medicines were being administered as prescribed.

### 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 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 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. Medicines management policies and procedures were in place.

## 4.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	0	4*

\* the total number of areas for improvement includes four which are carried forward for review at the next inspection.

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with the nurse in charge, as part of the inspection process and can be found in the main body of the report.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 4.8  <b>Stated:</b> First time  <b>To be completed by:</b> 31 May 2024	The registered person shall ensure that wound care plans reflect the recommended dressing frequency.
	<b>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.</b>  Ref 2.0
<b>Area for improvement 2</b>  <b>Ref:</b> Standard 12  <b>Stated:</b> First time  <b>To be completed by:</b> 31 May 2024	The registered person shall ensure that choking risk assessments are recorded accurately and reflect the current needs of the patient.
	<b>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.</b>  Ref 2.0
<b>Area for improvement 3</b>  <b>Ref:</b> Standard 21  <b>Stated:</b> First time  <b>To be completed by:</b> 31 May 2024	The registered person shall ensure that for those patients who require a fluid restriction: <ul style="list-style-type: none"> <li>• Detailed care plans are in place including the medical reason for the restriction and actions to be taken if deficits are identified.</li> <li>• Registered nurses document daily an evaluation of the patient's fluid intake and any actions required as necessary.</li> </ul>
	<b>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.</b>  Ref 2.0

<p><b>Area for improvement 4</b></p> <p><b>Ref:</b> Standard 46</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 30 April 2024</p>	<p>The registered person shall ensure the infection prevention and control deficits identified at this inspection are addressed:</p> <ul style="list-style-type: none"> <li>• Bumper covers are replaced or cleaned</li> <li>• Crash mats are replaced or cleaned</li> </ul>
	<p><b>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.</b></p> <p>Ref 2.0</p>

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



## The Regulation and Quality Improvement Authority

James House  
2-4 Cromac Avenue  
Gasworks  
Belfast  
BT7 2JA

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**Tel:** 028 9536 1111



**Email:** [info@rqia.org.uk](mailto:info@rqia.org.uk)



**Web:** [www.rqia.org.uk](http://www.rqia.org.uk)



**Twitter:** @RQIANews