The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Green Isle**

Provider: **Green Isle Residential Home Ltd**

Date of Inspection: **5 December 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:	Green Isle Residential Home Ltd
Responsible Individual:	Mrs Lesley Ann Coffey
Registered Manager:	Mrs Lesley Ann Coffey, not registered
Service Profile: Green Isle is a registered residential care home which provides health and social care for up to nine residents. Residents' bedrooms are located over two floors. The communal lounge and dining room are located on the ground floor. Residents have access to an attractive enclosed garden area.	

2.0 Inspection summary

An unannounced inspection took place on 5 December 2024, from 10.30am to 2.30pm. The inspection 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.

The outcome of this inspection indicated that robust arrangements were not in place for some aspects of medicines management. Areas for improvement were identified in relation to: governance and audit; the standard of maintenance of the personal medication records and controlled drug record book; care plans for distressed reactions and the secure storage of medicines. Whilst areas for improvement were identified, there was evidence that the majority of medicines were administered as prescribed.

Following the inspection, the findings of the inspection were discussed with the senior pharmacist inspector in RQIA and with the responsible individual. It was decided that the home would be given a period of time to implement the necessary improvements. A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained. Failure to implement and sustain the improvements may lead to enforcement.

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

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, and new areas for improvement identified, 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 residents, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

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 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.

Staff advised that they were familiar with how each resident liked to take their medicines. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

No completed questionnaires or responses to the staff survey were received 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?

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.

Some personal medication records were not up to date with the most recent prescription and some were incomplete. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff did not use these records as part of the administration of medicines process. Directions for the administration of medicines prescribed on a when required basis did not include maximum daily dosage or minimum intervals for administration. 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.

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, etc.

Residents 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 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 on the personal medication records. 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. However, person-centred care plans were either not in place or required more detail. An area for improvement was identified. There had been no recent administrations of these medicines; staff advised that the reason for administration and outcome are recorded when these medicines are administered.

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 plans were in place and reviewed regularly.

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 treatment room was observed to be securely locked to prevent any unauthorised access, however storage cupboards and the medicines refrigerator did not have individual locks. An area for improvement was identified.

The medicine storage area was tidy and organised so that medicines belonging to each resident 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 residents to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. All 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. A small number of pages in the controlled drug record were not completed fully and accurately i.e. the resident's full name and form of the controlled drugs had not been recorded. An area for improvement was identified.

The audits completed at the inspection indicated that the majority of medicines were administered as prescribed. However, the audits carried out by management and staff had not identified the issues identified at this inspection. The manager should implement a robust audit system which covers all aspects of the management and administration of medicines including those identified at this inspection. Any shortfalls identified should be detailed in an action plan and addressed. An area for improvement was identified.

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. The audits completed at the inspection indicated that medicines were administered as prescribed. However, personal medicine records had not been accurately completed as identified in Section 3.3.1.

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.

One medicine related incident had been reported to RQIA since the last medicine inspection. The findings of this inspection indicate that the auditing system is not robust and incidents may not be identified. The inspector signposted staff to the provider guidance in relation to the statutory notification of medication related incidents available on the RQIA website.

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. The audits were discussed in detail with the manager for on-going close vigilance.

As detailed in Section 3.3.3, a robust audit system should be implemented.

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. Medicines management policies and procedures were in place.

The manager advised that the findings of this inspection would be discussed with all staff to facilitate the necessary improvements.

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	4*	5*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Lesley Ann Coffey, Responsible Individual, 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 Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of inspection (5 December 2024)	The registered person shall ensure that personal medication records are accurate and up to date. Specifically: • entries match and reflect the prescriber's most recent instructions • 'when required' medications include maximum daily dosage and minimum dosing intervals Ref: 3.3.1 & 3.3.4
	Response by registered person detailing the actions taken: The entries into the medication records are being thoroughly looked over by three members of staff everytime a new medication comes in, if it happens to be wrong or doesn't match it will be brought to managments attention and they will get in contact with a pharmacy or GP to query this. The Central Prescription Records (Medication records) have all been updated with a maximum daily dosage for PRN or "when required" medication.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of inspection (5 December 2024)	The registered person shall review the management of controlled drugs to ensure records are accurately maintained. Ref: 3.3.3
	Response by registered person detailing the actions taken: All controlled drugs are up to date in the controlled drug book, the residents full names are documented in it along with the correct name and forms of the drugs.
Area for improvement 3 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of inspection (5 December 2024)	The registered person shall implement a robust audit system which covers all aspects of management of medicines. Any shortfalls should be detailed in an action plan and addressed. Ref: 3.3.3 and 3.3.5
	Response by registered person detailing the actions taken: All problems with medication have now been fully and properly recorded in the medication audits.

Area for improvement 4 **Ref:** Regulation 14 (2)(a)(c) **Stated:** First time **To be completed by:** From the date of inspection (4 September 2024)	The registered person shall ensure that dental cleaning tablets are safely stored in accordance with Control of Substance Hazardous to Health(COSHH) requirements.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 2.0
Action required to ensure compliance with the Care Standards for Residential Homes, December 2022	
Area for improvement 1 **Ref:** Standard 32 **Stated:** First time **To be completed by:** From the date of inspection (5 December 2024)	The registered person shall ensure there is appropriate locked storage for medications. Ref: 3.3.2
	Response by registered person detailing the actions taken: We have now purchased secure lockers for each individual residents medication and the keys are kept with the medication staff on duty and handed over and signed for at the end of each shift. All keys are labelled with the corresponding residents name and room number.
Area for improvement 2 **Ref:** Standard 6 **Stated:** First time **To be completed by:** From the date of inspection (5 December 2024)	The registered person shall ensure than person-centred care plans are in place for the administration of ‘when required’ medicines for the management of distressed reactions. Ref: 3.3.1
	Response by registered person detailing the actions taken: In the care plans under the mediactaion section for each resident it has been noted of each "when required medication" and the outcome of its use (if it has benefited the resident or not).
Area for improvement 3 **Ref:** Standard 20.10 **Stated:** First time **To be completed by:** 1 November 2024	The registered person shall ensure that staff`s registration with NISCC is regularly audited and documented.
	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: 2.0

Area for improvement 4 **Ref:** Standard 6.6 **Stated:** First time **To be completed by:** 1 November 2024	The registered person shall ensure care plans are kept up to date and reflects residents' current needs. This is stated in relation to the impact of a locked keypad on DOL safeguards. **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: 2.0
Area for improvement 5 **Ref:** Standard 13.9 **Stated:** First time **To be completed by:** 1 November 2024	The registered person shall ensure that a record is kept of all activities that take place within the home. **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: 2.0

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