

# Inspection Report

**Name of Service:** Lisnisky Residential Home

**Provider:** Ann's Care Homes

**Date of Inspection:** 3 June 2025

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

## 1.0 Service information

<b>Organisation/Registered Provider:</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 Residential Home is a residential care home which provides health and social care for up to 19 residents. Each resident has their own bedroom and residents also have access to communal areas with secure outside spaces.</p> <p>There is a nursing home located under the same roof and the manager for this home manages both services.</p>	

## 2.0 Inspection summary

An unannounced inspection took place on 3 June 2025, from 10.10 am to 1.00pm. The inspection was completed by two pharmacist inspectors 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 inspection also reviewed the area for improvement identified at the last care inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and there was evidence that with the exception of a small number of medicines, residents were being administered their medicines as prescribed. However, improvements were necessary in relation to storage of controlled drugs, management of mid cycle changes and disposal of expired medicines.

The area for improvement in relation to distressed reaction identified at the last care inspection was assessed as met. Details of the inspection findings, including 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).

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.

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 and medicines were administered in accordance with individual resident preference.

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.

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 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, modified diets etc.

The management of distressed reactions and pain were reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed.

### **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.

When a medicine is discontinued the personal medication record and medicine administration record must be updated and verified by two trained staff. The stock must be removed from the blister pack system/trolley and overstock cupboard and disposed of appropriately to ensure that it is not administered in error.

For one resident records had been updated appropriately following a recent medication change. However, the discontinued medicine remained in the blister pack system. The discontinued medicine was removed from the blister pack system for disposal at each medicine round. This practice is unsafe as an incorrect medicine may be removed for disposal or staff may administer the medicine in error. An area for improvement was identified.

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 medicine 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 safe disposal of medicines.

One controlled drug which was subject to safe custody requirements was being stored outside of the controlled drug cabinet. An area for improvement was identified.

### **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. Most of the records were found to have been accurately completed. A small number of missed second verification signatures were brought to the attention of the manager for ongoing monitoring. 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. Records for the receipt, administration and disposal of controlled drugs were accurately maintained. An area for improvement was identified in relation to the storage arrangements for controlled drugs. See Section 3.3.2.

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 action plans had been implemented and addressed. The date of opening was recorded on the majority of medicines to facilitate audit and disposal at expiry. A small number of missing dates of opening were highlighted to the manager for ongoing vigilance.

A number of medicines, including eye drops, have a limited expiry date once in-use. Eye drops were observed to be in use for one resident past the date of expiry. 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. 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.

There had been no medicine related incidents reported to RQIA since the last medicines management inspection. Management and staff advise that they were familiar with the type of incidents that should be reported. The inspector signposted staff to the RQIA 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.

### 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.

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

## 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
<b>Total number of Areas for Improvement</b>	2	1

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Sherly Mathai, Registered Manager and the regional manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with The Residential Home Regulations (Northern Ireland) 2005</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 13 (4)  <b>Stated:</b> First time  <b>To be completed by:</b> 3 June 2025	<p>The registered person shall ensure controlled drugs subject to safe custody requirements are stored securely in compliance with the Misuse of Drugs (Safe Custody) (Northern Ireland) Regulations 1973.</p> <p>Ref: 3.3.2</p>
	<p><b>Response by registered person detailing the actions taken:</b>            The registered person has completed supervision with all Senior Care Assistants and covered safe storage of controlled drugs. This will be covered in medication training arranged for Seniors. Compliance will be monitored through spot checking and auditing process.</p>
<b>Area for improvement 2</b>  <b>Ref:</b> Regulation 13 (4)  <b>Stated:</b> First time  <b>To be completed by:</b> 3 June 2025	<p>The registered person shall ensure medicines, including eye preparations, are disposed of at of expiry.</p> <p>Ref: 3.3.3</p>
	<p><b>Response by registered person detailing the actions taken:</b>            The registered person has completed supervision with all Senior Care Assistants covering the importance of checking expiry dates and disposing same correctly. This will be covered in medication training arranged for Seniors. Compliance will be monitored through spot checking and auditing process.</p>
<b>Action required to ensure compliance with the Care Standards for Residential Homes, December 2022</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 30  <b>Stated:</b> First time  <b>To be completed by:</b> 3 June 2025	<p>The registered person shall review the management of medicine changes to ensure safe systems are in place.</p> <p>Ref: 3.3.2</p>
	<p><b>Response by registered person detailing the actions taken:</b>            The registered person completed supervision with all Senior Care Assistants covering the importance of how changes in medication should be managed. This will be covered in medication training arranged for Seniors. Compliance will be monitored through spot checking and auditing process.</p>



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