The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Innisfree

Provider: Innisfree

Date of Inspection: 18 November 2025

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:	Innisfree
Responsible Individual:	Mrs Shauna Stanford
Registered Manager:	Miss Emma Johnston, not registered
Service Profile: Innisfree is a residential care home registered to provide health and social care for up to 28 residents. The home is situated on the ground floor of the building. Residents have access to communal lounges, bathrooms, a dining room and a patio and garden area.	

2.0 Inspection summary

An unannounced inspection took place on 18 November 2025, from 10.00am to 3.15pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The findings of the medicines management inspection on 26 August 2025 evidenced that safe systems were not in place for some aspects of medicines management. Areas for improvement were identified in relation to; records regarding the management of distressed reactions, the management of warfarin, the disposal of medicines, the management of changes to prescribed medicines, records of outgoing medicines, controlled drug records and audit procedures. The management team were given a period of time to address the issues identified. This follow-up inspection was undertaken to evidence if the necessary improvements had been implemented and sustained. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Six of the seven areas for improvement identified at the last medicines management inspection were assessed as met. However, the area for improvement in relation to records of outgoing medicines has been stated for a second time. A new area for improvement was identified in relation to records of incoming medicines. Details can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

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.

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 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.

Staff said they had worked hard to implement and sustain improvements identified at the last medicines management inspection and had received help and support from senior management to do so. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

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 electronic personal medication records reviewed were mostly accurate and up to date (see below). In line with best practice, a second member of staff had verified the records when they were initiated and updated to confirm that they were accurate. A small number of minor discrepancies were highlighted for immediate corrective action and on-going vigilance.

Copies of hospital discharge letters and most residents' prescriptions 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, pain, insulin and warfarin was 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.

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 record. Care plans were in place; however, two needed to be updated to reflect recent changes to the prescription. Staff completed these updates following the inspection and forwarded the updates to the inspector for review. 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 included the reason for and usually the outcome of each administration, staff were reminded that this should be recorded on every occasion.

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.

Care plans were in place when residents required insulin to manage their diabetes. There was sufficient detail to direct staff if the resident's blood sugar was outside of the recommended range. The insulin prescribed was documented on the personal medication record.
The management of warfarin was reviewed. Warfarin is a high-risk medicine, which requires regular blood testing. The dose of warfarin prescribed depends on the blood test result. Warfarin had been administered as prescribed and a resident specific care plan was in place. A running balance was maintained for each strength of warfarin to enable discrepancies to be identified.

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 the majority of medicines were available for administration when residents required them; however, medicine doses had been omitted on a couple of occasions, as the medicines were not available in the home. There was evidence that action had recently been taken to resolve this, the manager had recently introduced a new communication record for staff. The manager was reminded that when medicines are out of stock and this cannot be rectified immediately, this should be reported to the prescriber for advice and to RQIA as a medication incident notification. All medicines were available for administration on the day of the inspection.

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. 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, the storage of controlled drugs and the safe disposal of medicines. Staff were reminded to reset the refrigerator thermometer each day after recording temperatures.

The date of opening was recorded on medicines to facilitate audit and medicines with a reduced expiry date once opened were within their expiry date.

Records of outgoing medicines completed since the last medicines management inspection, correlated with medicines recorded as transferred/disposed of in the controlled drug record book. However, records for other medicines were not recorded in chronological order, since several record books and loose sheets were in use and a number of entries had not been verified with two signatures. This is necessary to facilitate a clear audit trail. An area for improvement was stated for a second time.

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.

Records of incoming medicines, including individual medicines received in monitored dosage systems and some medicines for new residents, had not always been accurately completed. This is necessary to facilitate a clear audit trail (see section 3.3.4). An area for improvement was identified.

A sample of the electronic medicines administration records was reviewed. Most of the records were found to have been accurately completed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong painkillers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. Arrangements had been reviewed following the last inspection and satisfactory arrangements were in place for the management of controlled drugs.

Management and staff had audited the management and administration of medicines on a regular basis within the home. The manager had reviewed the audit system in place and any shortfalls identified had been detailed in an action plan and addressed. It was agreed that this would be sustained and reviewed regularly, along with the quality improvement plan.

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.

The arrangements in place to manage medicines at the time of admission or for residents returning from hospital were reviewed. 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. However, medicines received had not always been accurately recorded (see section 3.3.3).

Changes to medicines supplied in the monitored dosage system, had been completed by the community pharmacist, in accordance with the home's procedure.

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 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. However, audit discrepancies were observed in the administration of a small number of medicines. The audits were discussed in detail with the staff on duty and the manager for on-going monitoring.

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 improvements.

4.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	2*	4

* the total number of areas for improvement includes one that has been stated for a second time and four which were carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Miss Emma Johnston, 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 Residential Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** Second time **To be completed by:** 18 November 2025	The registered person shall ensure that records of outgoing medicines are accurately maintained and include the date, the reason for disposal/transfer and two signatures to evidence this. Ref: 2.0 & 3.3.2
	Response by registered person detailing the actions taken: The registered person shall that records of outgoing medicines are maintained accuratley and will include date, reason fr disposal/tranfer. Two members of staff will sign to evidence this.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 18 November 2025	The registered person shall ensure that records of all incoming medicines are accurately maintained. Ref: 3.3.3 and 3.3.4
	Response by registered person detailing the actions taken: The registered person shall ensure records of all incoming medications are accurately maintained.
Action required to ensure compliance with the Care Standards for Residential Homes, December 2022	
Area for improvement 1 **Ref:** Standard 25.6 **Stated:** First time **To be completed by:** 8 July 2025	The registered person shall ensure that a record is kept of all staff working over a 24-hour period and the capacity in which they worked.
	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 2 **Ref:** Standard 6.6 **Stated:** First time **To be completed by:** 31 July 2025	The registered person shall ensure that care plans with regards to DoLs are kept up to date and reflect the resident's current needs.
	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 3 **Ref:** Standard 27 **Stated:** First time **To be completed by:** 30 September 2025	The registered person shall ensure that the premises and grounds are safe, well maintained and remain suitable for their stated purpose. **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 35 **Stated:** First time **To be completed by:** 8 July 2025	The registered person shall ensure the infection prevention and control issues identified on the inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the correct storage of personal protective equipment. **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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