The Regulation and Quality Improvement Authority

# Inspection Report

**Name of Service:** Magherafelt Manor Residential Home

**Provider:** Kathryn Homes Limited

**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

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| **Organisation/Registered Provider:** | Kathryn Homes Limited |
| **Responsible Individual:** | Mrs Tracey Anderson |
| **Registered Manager:** | Ms Siobhan Conway |
| **Service Profile:**<br>Magherafelt Manor Residential Home is a residential care home registered to provide health and social care for up to 28 residents living with dementia.<br><br>This home shares the same building as Magherafelt Manor Nursing Home. The registered manager is responsible for both services. | |

## 2.0 Inspection summary

An unannounced inspection took place on 5 December 2024, from 10.20am to 2.25pm. 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 inspection also reviewed the areas for improvement identified at the last care inspection.

Review of medicines management found that mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care records accurately maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. However, improvements in some areas of the management of medicines were necessary. New areas for improvement were identified in relation to cancelling and archiving obsolete medicine records, records for medicines administered for the management of distressed reactions and records of outgoing controlled drugs.

Whilst areas for improvement were identified, there was evidence that 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 them well.

The two areas for improvement identified at the last care inspection were assessed as met. Details of the inspection findings, including the 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 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.

## 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.

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?

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.

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.

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.

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 and care plans 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 consistently include the reason for and outcome of each administration. An area for improvement was identified.

The management of warfarin was reviewed. Warfarin is a high risk medicine which requires regular blood testing and the dose of warfarin prescribed depends on the blood test result.

Information on the dose of warfarin had not been cancelled and archived when an update on the dosage regimen was received. This is necessary to ensure that staff do not refer to obsolete directions in error. An area for improvement was identified in relation to cancelling and archiving records (see above).

The management of pain and thickening agents were also 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.

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 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.

It was agreed that inhaler spacer devices would be covered when stored in medicine trolleys, for infection prevention and control purposes.

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. For two medicines which had been disposed of, the balance in the controlled record book had not been closed and there was no entry in the outgoing medicines book. This is necessary to

facilitate audit and provide evidence that the medicines have been returned to the community pharmacy for disposal. The manager completed an investigation and a report was received by RQIA following the inspection. An area for improvement was identified regarding the records maintained for outgoing medicines.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on the majority of medicines; staff were reminded that this should be recorded on all medicines so that they can be easily audited.

It was agreed that the issues identified at this inspection would be addressed within audit procedures and discussed with staff, to ensure that improvement is sustained.

### 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.

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. 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. 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 Regulations and Standards.

| | Regulations | Standards |
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| **Total number of Areas for Improvement** | 1 | 2 |

Areas for improvement and details of the Quality Improvement Plan were discussed with the deputy manager as part of the inspection process. The timescales for completion commence from the date of inspection.

## Quality Improvement Plan

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| **Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005** | |
| **Area for improvement 1**<br><br>**Ref:** Regulation 13 (4)<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With immediate effect<br>(5 December 2024) | The registered person shall ensure that records of outgoing medicines are accurately maintained.<br><br>Ref: 3.3.3 |
| | **Response by registered person detailing the actions taken:**<br>A Supervision was completed with the members of staff.<br>Pharmacist training with all the Senior Care assistants took place.<br>The Controlled Drug register book is brought daily to the Heads of Department Meeting and checked by the Home Manager/Deputy Manager.<br>There are now enhanced CD register checks/audits being completed. |
| **Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022** | |
| **Area for improvement 1**<br><br>**Ref:** Standard 31<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With immediate effect<br>(5 December 2024) | The registered person shall ensure that obsolete medicines records are cancelled and archived promptly.<br><br>Ref: 3.3.1 |
| | **Response by registered person detailing the actions taken:**<br>All Obsolate Kardex are removed and marked discontinued. A maximum of one most recent Kardex is available in the Kardex folder for reference purposes only.<br>These are clearly marked as discontinued. Checks completed by the Home Manager/Deputy Manager. |
| **Area for improvement 2**<br><br>**Ref:** Standard 10<br><br>**Stated:** First time<br><br>**To be completed by:**<br>With immediate effect<br>(5 December 2024) | The registered person shall ensure that the reason for and the outcome of administration are recorded on every occasion, when medicines are used on a 'when required' basis for the management of distressed reactions.<br><br>Ref: 3.3.1 |
| | **Response by registered person detailing the actions taken:**<br>PRN protocol recording folder is in place and this is checked daily by the Home Manager/Deputy manager. The Controlled Drug register is checked daily at the Heads of Department meetings by the Home/Deputy manager. Staff have attended Pharmacy training and this was addressed. Spot checks are also completed. |

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