The Regulation and Quality Improvement Authority

Inspection Report

11 January 2023

Mahon Hall

Type of service: Residential Care Home
Address: 16 Mahon Road, Portadown, Craigavon, BT62 3EF
Telephone number: 028 3835 0981

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: Ann's Care Homes **Responsible Individual:** Mrs Charmaine Hamilton	**Registered Manager:** Ms Zoe Lewis **Date registered:** 23 February 2021
Person in charge at the time of inspection: Ms Zoe Lewis	**Number of registered places:** 13
Categories of care: Residential Care (RC): DE – dementia	**Number of residents accommodated in the residential care home on the day of this inspection:** 10
Brief description of the accommodation/how the service operates: Mahon Hall is a residential care home which is registered to provide care for up to 13 residents. This home is situated on the same site as Mahon Hall nursing home.	

2.0 Inspection summary

An unannounced inspection took place on 11 January 2023, from 10.35 am to 2.10pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

Review of medicines management found that residents were being administered their medicines as prescribed. The majority of medicine records were well maintained. Staff had received training and been deemed competent to manage and administer medicines. There were arrangements for auditing medicines. However, improvements in the standard of maintenance of hand-written medication administration records were necessary. In addition, one medication related incident identified at a recent community pharmacy audit had not been reported to RQIA. Two areas for improvement were identified.

Although areas for improvement were identified, based on the inspection findings and discussions held, RQIA are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is will led by the management team in relation to medicines management.

RQIA would like to thank the staff and management for their assistance throughout the inspection.

3.0 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 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 previous inspection findings, incidents and correspondence. To complete the inspection the following were reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke with staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with one care assistant, one senior carer and the manager.

Staff were warm and friendly and it was evident from discussions that they knew the residents well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The staff members spoken with expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any resident or their family representative to complete and return using pre-paid, self-addressed envelopes.

At the time of issuing this report, no questionnaires had been received by RQIA.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

The last inspection of this residential care home was undertaken by a care inspector on 29 September 2022; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 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 at the inspection were accurate and up to date. In line with safe 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. The manager and staff were reminded that only the current personal medication record should be available on the medicines file to ensure that staff do not refer to out of date records in error. Obsolete personal medication records were cancelled and archived during the inspection. The manager advised that this would be monitored through the audit process.

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. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour and were aware that this change may be associated with pain, infection or constipation. Directions for use were clearly recorded on the personal medication records. Care plans directing the use of these medicines were available. Records of administration and the reason for and outcome of administration were recorded.

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 and pain assessments were in place and reviewed regularly.

Some residents 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 resident 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 resident.

The management of thickening agents was reviewed for two residents. Speech and language assessment reports and care plans were in place. Records of prescribing and administration, which included the recommended consistency level, were maintained.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines 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.

The records inspected 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 medicines 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.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. Mostly satisfactory systems were in place for monitoring the temperature of the medicines refrigerator; a small number of temperatures were outside the recommended range and this was discussed with staff on duty and the manager for on-going close monitoring. The area for improvement identified at the medicines management inspection on 4 March 2021 was assessed as met. There were no medicines which required cold storage at the time of the inspection.

Appropriate arrangements were in place for the disposal of medicines.

5.2.3 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 record of the administration of medicines was completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. The records had been completed in a mostly satisfactory manner. However, some hand-written medication administration records had not been verified and signed by two

members of staff to ensure accuracy. In addition the month and year of administration had not been recorded. An area for improvement was identified.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The records of receipt, administration and disposal of controlled drugs were maintained to the required standard.

Management and staff audited the management and administration of medicines on a regular basis within the home. In addition, running stock balances were maintained for medicines following each administration so that any error would be identified immediately. The audits completed at the inspection indicated that medicines were administered as prescribed.

5.2.4 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 admission process for residents new to the home or residents returning from hospital was reviewed. Arrangements were in place to ensure that staff were provided with a current list of the resident's medicines and this was shared with the community pharmacist and GP. The personal medication records were verified and signed by two staff to ensure accuracy of transcription. However, as identified in Section 5.2.3, hand-written medication administration records had not been verified and signed by two members of staff and the month and year of administration had not been recorded.

5.2.5 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.

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 learning shared with staff in order to prevent a recurrence.

The audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported. However, one medication incident which had been identified at a recent audit completed by the community pharmacist had not been reported to RQIA. The manager was reminded that all medication related incidents should be investigated to identify learning, reported to the prescriber for guidance and to RQIA. An area for improvement was identified.

5.2.6 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 staff are competent in managing medicines and they are supported. Policies and procedures should be up to date and readily available.

Staff in the home had received a structured induction which included medicines management when this was part of their role. Update training and competency assessments were completed following induction and annually thereafter. Records were available for inspection.

The manager advised that the findings of this inspection would be shared with all staff for ongoing improvement.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Home Regulations (Northern Ireland) 2005 and The Residential Care Homes Minimum Standards 2021.

	Regulations	Standards
Total number of Areas for Improvement	1	1

The areas for improvement and details of the Quality Improvement Plan were discussed with Ms Zoe Lewis, Registered 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 Care Home Regulations (Northern Ireland) 2005	
Area for Improvement 1 **Ref:** Regulation 30 **Stated:** First time **To be completed by:** Immediate action required (11 January 2023)	The registered person shall submit an incident report to RQIA as detailed in the report. Ref. 5.2.5
	Response by registered person detailing the actions taken: The Registered Person submitted the Reg 30 retrospectively on 13.2.23 for medication error as indicated within report. This was investigated at home level and concluded that issue was a GP omission of clear instruction and the chemist did not pick up issue with both tablets at time of dispensing.
Action required to ensure compliance with Residential Care Homes Minimum Standards 2021	
Area for improvement 1 **Ref:** Standard 31 **Stated:** First time **To be completed by:** Immediate action required (11 January 2023)	The registered person shall ensure that hand-written medication administration records are verified and signed by two staff and include the date of administration (day, month and year). Ref 5.2.3 & 5.2.5
	Response by registered person detailing the actions taken: The Registered Person has completed supervision with all Seniors to highlight that all hand written medication administration records are verified and signed by two staff to include the date of administration day, month and year. Registered Manager will monitor compliance during monthly medication audit and will utilise walkabout form to record spot checks made on medication records. This will also be discussed at planned Senior meeting in March 23.

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

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