Inspection Report
4 March 2021

Mahon Hall

Type of Home: Residential Care Home
Address: 16 Mahon Road, Craigavon, Portadown BT62 3EF
Tel No: 028 3835 0981
Inspector: Helen Daly

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a residential care home which is registered to provide care for up to 13 residents who are living with dementia. It is situated in the same building as Mahon Hall Nursing Home.

2.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Mrs Natasha Southall, registration pending	**Registered Manager and date registered:** Ms Zoe Lewis 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	**Total number of residents in the residential care home on the day of this inspection:** 11

3.0 Inspection focus

Following a risk assessment and to reduce the risk to residents during the pandemic, this inspection was carried out remotely.

The home manager was requested to submit a range of documents and completed records in relation to medicines management to RQIA. These were received by RQIA on 22 February 2021 and reviewed by the pharmacist inspector.

This inspection was completed following a review of information requested and submitted to RQIA on 22 February 2021. This information included the completion of a self-assessment

specific to medicines management in the home. Feedback was discussed with the manager on 4 March 2021.

This inspection focused on medicines management within the home and followed up on one medicines related area for improvement in the last Quality Improvement Plan (QIP).

Following discussion with the care inspector it was agreed that the areas for improvement in relation to care, would not be reviewed at this inspection, but would be assessed at the next care inspection.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

As part of the inspection process we:

- spoke to representatives of the residents via telephone
- spoke to management about how they plan, deliver and monitor the care and support provided in the home
- reviewed the submitted documents to confirm that appropriate records were kept

The following areas regarding medicines management were examined and/or discussed:

- personal medication records
- medicine administration records
- disposal of medicines
- care plans related to medicines management
- governance and audit
- controlled drugs
- staff training and competency
- medicine storage temperatures
- completed medicines management self assessment

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	3*

*The total number of areas for improvement includes two that has been carried forward for review at the next care inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Ms Zoe Lewis, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

5.0 What has this home done to meet any areas for improvement from the last inspection (30 June 2020)?

<table>
<tr><th colspan="3">Areas for improvement from the last inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 30

Stated: First time</td><td>The registered person shall review and revise the management of warfarin.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
The management of warfarin had been reviewed and revised. Dosage directions were received in writing. These directions were transcribed onto a warfarin administration chart. The transcribed details had been verified and signed by two members of staff. Running stock balances were maintained.

The manager advised that obsolete dosage directions were cancelled and archived and that only the current directions were available on the medicines file.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 5.5

Stated: First time</td><td>The registered person shall ensure the assessment of needs is reviewed and updated for the identified resident</td><td rowspan="2">Carried forward to the next care inspection</td></tr>
<tr><td>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.</td></tr>
<tr><td rowspan="2">Area for improvement 3

Ref: Standard 6.6

Stated: First time</td><td>The registered person shall ensure the care plan and evaluation regarding the management of distressed reactions is reviewed and updated for the identified resident.</td><td rowspan="2">Carried forward to the next care inspection</td></tr>
<tr><td>Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.</td></tr>
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6.0 What people told us about this home?

We asked the manager to provide contact details for residents' relatives/representatives who gave consent to be contacted by the inspector. We spoke with five residents' relatives. They said that they were "satisfied/very satisfied" with the care provided to the residents.

Comments made were positive and included:

"Staff are on the ball. X (relative) has not had many issues but they let me know if anything at all happens."

"I am very happy with X's care. I can never repay the staff."

"I have no problem with the care given to my X. I am more than happy with the unit and the staff."

"They are very good to my X. Overall I am very happy with the care. Staff are good at communicating if there are issues."

"I am more than happy with the care. There is regular communication e.g. information about the vaccine, birthday videos. "

Other feedback methods included posters which were provided for the manager to display so that staff and/or residents could complete a questionnaire. At the time of issuing this report, no responses had been received.

7.0 Inspection Findings

7.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in 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 will 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 a community pharmacist.

Personal medication records were in place. These are records used to list all 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 e.g. at medication reviews, 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 provide a double check that they were accurate.

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, self-administration etc.

The management of pain was reviewed for two residents. Care plans were in place and the records of prescribing and administration indicated that medicines were administered as prescribed. The manager was reminded that when medicines are prescribed at variable dose for example, one or two tablets, the actual dose administered must be recorded.

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.

We reviewed the management of thickening agents and nutritional supplements for one resident. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

The manager advised that medicines for the management of distressed reactions were not currently prescribed.

7.2 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. The manager advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

We discussed the disposal arrangements for medicines. Discontinued medicines, including controlled drugs, were returned to the community pharmacy for disposal and records maintained.

Medicines storage was discussed. The manager advised that all medicines were stored securely in the treatment room which was securely locked to prevent any unauthorised access and that medicines belonging to each resident could be easily located

The manager advised that any medicines requiring cold storage were stored in the medicines refrigerator. The records reviewed indicated that the thermometer was not being reset each day. This had also been observed at the last medicines management inspection and discussed

for immediate corrective action. As the necessary action had not been implemented an area for improvement was identified. The thermometer must be reset each day after the temperatures have been recorded in order to accurately monitor the refrigerator temperature over the 24 hour period.

7.3 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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed and found to have been fully and accurately completed. See also Section 7.1.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The manager advised that the receipt, administration and disposal of controlled drugs were recorded in a controlled drug record book. Stock balances were checked at each handover of responsibility.

The manager had submitted a range of audits which indicated that medicines had been administered as prescribed. Action plans to address any shortfalls in the management of medicines had been implemented and addressed.

7.4 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.

We reviewed the management of medicines for two residents who had been admitted/ readmitted to the home. Hospital discharge letters had been received and a copy had been forwarded to the residents' GPs. The residents' personal medication records correlated with the discharge instructions. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

7.5 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 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.

We discussed the medicine related incidents which had been reported to RQIA. 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.

7.6 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 that staff are supported.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. Records of staff training and competency assessment were submitted for review.

8.0 Evaluation of Inspection

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

We can conclude that overall the residents were administered their medicines as prescribed by their GP. Feedback from residents' families was positive.

One area for improvement in relation to accurately monitoring the refrigerator temperature was identified.

We would like to thank the management and staff for their assistance prior to and throughout the inspection. We would also like to thank the relatives who provided feedback on the care provided in the home.

9.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Ms Zoe Lewis, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

9.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

9.2 Actions to be taken by the home

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 5.5 **Stated:** First time **To be completed by:** 14 July 2020	The registered person shall ensure the assessment of needs is reviewed and updated for the identified resident. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.** Ref: 5.0
Area for improvement 2 **Ref**: Standard 6.6 **Stated:** First time **To be completed by:** 14 July 2020	The registered person shall ensure the care plan and evaluation regarding the management of distressed reactions is reviewed and updated for the identified resident. **Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.** Ref: 5.0
Area for improvement 3 **Ref**: Standard 32 **Stated:** First time **To be completed by:** From the date of the inspection onwards	The registered person shall ensure that the medicine refrigerator temperature is accurately monitored and recorded each day. The thermometer should be reset each day after the maximum and minimum temperatures have been recorded. Ref: 7.2 **Response by registered person detailing the actions taken:** The Registered Manager has completed supervision with all Senior Care Assistants which includes how to monitor and record the daily temperature. Also how to reset the thermometer each day after the maximum and minimum temperature is recorded.

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

The **Regulation** and **Quality Improvement Authority**

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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