

# Inspection Report

5 September 2022



## Madelayne Court

Type of service: Residential (RC)

Address: Downhill Suite, 1-27 Nursery Avenue, Portstewart  
BT55 7LG

Telephone number: 02870831014

[www.rqia.org.uk](http://www.rqia.org.uk)

---

Assurance, Challenge and Improvement in Health and Social Care

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> Kathryn Homes Ltd  <b>Responsible Individual :</b> Mr Stuart Johnstone	<b>Registered Manager:</b> Mrs Araceli Flores – not registered
<b>Person in charge at the time of inspection:</b> Mrs Araceli Flores	<b>Number of registered places:</b> 18  The home is approved to provide care on a day basis to 1 person.
<b>Categories of care:</b> Residential Care (RC) I – old age not falling within any other category.	<b>Number of residents accommodated in the residential care home on the day of this inspection:</b> 16
<b>Brief description of the accommodation/how the service operates:</b>  This home is a registered residential care home which provides health and social care for up to 18 residents. Residents have access to communal lounges and a dining room. There is a garden area to the rear of the home.  There is also a registered nursing home located within the same building for which the manager also has operational responsibility and oversight.	

## 2.0 Inspection summary

An unannounced inspection took place on 5 September 2022, from 10.00am to 1.45pm. This 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. The inspection also assessed progress with one of the areas for improvement identified at the last inspection. The remaining areas for improvement have been carried forward for review at the next care inspection.

Review of medicines management identified medicines were stored safely and securely. Medicine related records were maintained to a satisfactory standard and there were satisfactory arrangements in place for the management of controlled drugs.

Three new areas for improvement were identified during this inspection. Areas for improvement are detailed in the quality improvement plan and include records for the receipt of medicines, medicines audit and notifying RQIA of any incident which adversely affects the health and well-being of residents.

Whilst areas for improvement were identified, RQIA can conclude that overall, with the exception of a small number of medicines, the residents were being administered their medicines as prescribed.

RQIA would like to thank the residents and staff 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 they were 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. The inspection was completed by examining a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke to 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 senior care staff, care staff and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well.

The staff members spoken with expressed satisfaction with how the home was managed and the training received. They said that despite recent staffing pressures 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?

Areas for improvement from the last inspection on 9 June 2022		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		Validation of compliance
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 21 (1) (b)  <b>Stated:</b> First time	The registered person shall ensure the appropriate pre-employment checks are made before making an offer of employment.	<b>Carried forward to the next inspection</b>
	<b>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.</b>	
<b>Area for improvement 2</b>  <b>Ref:</b> Regulation 13 (4)  <b>Stated:</b> First time	The registered person shall ensure that medicines are not pre-dispensed prior to administration.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> Observation of the lunch time medicines round identified medicines were not pre-dispensed prior to administration. Medicines were administered to one resident at a time and the appropriate records completed at the time of administration.	
<b>Area for improvement 3</b>  <b>Ref:</b> Regulation 16 (2) (b)  <b>Stated:</b> First time	The registered person shall ensure that resident care plans are kept under review and reflect recommendations of the multidisciplinary team.	<b>Carried forward to the next inspection</b>
	This area for improvement is made with specific reference to the management of weight loss.	
	<b>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.</b>	

Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)		Validation of compliance
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 6.6  <b>Stated:</b> First time	The registered person shall ensure that resident care plans are person centred and are personalised to the specific resident.	<b>Carried forward to the next inspection</b>
	<b>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.</b>	

## 5.2 Inspection findings

### 5.2.1 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 the residents' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, the 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 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 in the home so that any entry on the personal medication record could be checked against the prescription. This is good practice.

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 and reviewed regularly.

### **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 the majority of medicines were available for administration when residents required them. However, it was identified that two medicines; an anticoagulant and a medicine for the management of epilepsy had been out of stock for one day resulting in missed doses. Senior care staff had not escalated this to management and action had not been taken in a timely manner to ensure a continuous supply of the resident's prescribed medicines. These missed doses had not been reported to RQIA as a medication incident. RQIA must be notified of any incident that adversely affects the health or wellbeing of any patient. An area for improvement was identified.

The medicines 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. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the safe disposal of medicines and records were maintained.

### **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 sample of the medicines administration records was reviewed. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. The records were filed once completed and were readily retrievable for 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 were recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

The audit process for medicines management was reviewed. A range of audits were completed including a recent community pharmacy support visit. Weekly medication administration checks were also completed and records available for review in the medicines file. Whilst daily running stock balances were in place for all medicines not supplied in monitored dosage sachets, it was noted that when discrepancies were identified by senior care staff, corrective action had not been taken and it had not been escalated to the manager.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, as stated in Section 5.2.2, missed doses of two medicines were observed as they were out of stock. Audit discrepancies were observed in the administration of a small number of medicines not supplied in monitored dosage sachets, including medicines for Parkinson's disease and an anticoagulant medicine.

These discrepancies indicate the current audit process requires expansion to ensure medicines not supplied in monitored dosage sachets are administered as prescribed. The need for a robust audit system which covers all aspects of medicines is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff. An area for improvement was identified.

#### **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 management of medicines for one resident recently admitted to the home from their usual residence was reviewed. A current list of the resident's medicines had been obtained from the GP and this was shared with the community pharmacist. The personal medication record had been written accurately and checked by a second member of staff. However, medicines which had been received into the home on admission had not been recorded in the medicines receipt book. This is necessary to facilitate audit and it could therefore not be determined if the medicines had been administered as prescribed. An area for improvement was identified.

#### **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. A robust audit system will help staff to identify medicine related incidents.

There have been no medicine related incidents reported to RQIA since September 2018. The findings of this inspection indicate that the auditing system is not robust and hence incidents may not be identified. As stated in Section 5.2.3, the need for a robust audit system which covers all aspects of medicines is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff.



### 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 for staff.

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. A written record was completed for induction and competency assessments.

As stated in Section 5.2.2, care staff should receive guidance on the action to be taken when they identify a shortfall in the management or administration of medicines.

## 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 Homes Regulations (Northern Ireland) 2005 and the Residential Care Homes Minimum Standards 2011.

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	4*	2*

\* The total number of areas for improvement includes three which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Araceli Flores, 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	
<b>Area for improvement 1</b>  <b>Ref:</b> Regulation 21 (1) (b)  <b>Stated:</b> First time  <b>To be completed by:</b> Immediate action required (9 June 2022)	<p>The registered person shall ensure the appropriate pre-employment checks are made before making an offer of employment.</p> <p><b>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.</b></p> <p>Ref: 5.1</p>
<b>Area for improvement 2</b>  <b>Ref:</b> Regulation 16 (2) (b)  <b>Stated:</b> First time  <b>To be completed by:</b> 9 July 2022	<p>The registered person shall ensure that resident care plans are kept under review and reflect recommendations of the multidisciplinary team.</p> <p>This area for improvement is made with specific reference to the management of weight loss.</p> <p><b>Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.</b></p> <p>Ref: 5.1</p>
<b>Area for improvement 3</b>  <b>Ref:</b> Regulation 30  <b>Stated:</b> First time  <b>To be completed by:</b> Ongoing from the date of inspection (5 September 2022)	<p>The registered person shall ensure:</p> <ul style="list-style-type: none"> <li>- RQIA are notified of any incident that adversely affects the health or wellbeing of any resident.</li> <li>- Care staff receive guidance on the action to be taken when they identify a shortfall in the management or administration of medicines.</li> </ul> <p>Ref: 5.2.2 &amp; 5.2.6</p> <p><b>Response by registered person detailing the actions taken:</b></p> <p>A new more robust medication system has been implemented which will assist to identify any short falls in medication administration. A daily carry forward of boxed medications check is also being performed.</p> <p>Home Manager will ensure that the RQIA are notified of any incidents that adversely affects the health and well being of residents.</p>

<p><b>Area for improvement 4</b></p> <p><b>Ref:</b> Regulation 13 (4)</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> Ongoing from the date of inspection (5 September 2022)</p>	<p>The registered person shall implement a robust audit system which covers all aspects of the management of medicines including the administration of medicines not supplied in monitored dosage sachets.</p> <p>Ref: 5.2.3 &amp; 5.2.5</p> <p><b>Response by registered person detailing the actions taken:</b></p> <p>A daily count of boxed medications is being carried out which easily identifies missed or missing drugs. A seven day out of stock system is in place to request medications that are in low supply.</p>
<p><b>Action required to ensure compliance with the Residential Care Homes Minimum Standards (August 2011) (Version 1:1)</b></p>	
<p><b>Area for improvement 1</b></p> <p><b>Ref:</b> Standard 6.6</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> 9 July 2022</p>	<p>The registered person shall ensure that resident care plans are person centred and are personalised to the specific resident.</p> <p><b>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.</b></p> <p>Ref: 5.1</p>
<p><b>Area for improvement 2</b></p> <p><b>Ref:</b> Standard 31</p> <p><b>Stated:</b> First time</p> <p><b>To be completed by:</b> Ongoing from the date of inspection (5 September 2022)</p>	<p>The registered person shall ensure records of the receipt of medicines, including medicines brought into the home by newly admitted residents, are fully and accurately maintained.</p> <p>Ref: 5.2.4</p> <p><b>Response by registered person detailing the actions taken:</b></p> <p>A binded book has been provided for the receipt of medications brought into the home. A new system has been implemented for the receipt of medications received from the pharmacy. This will highlight ordered medications that have not been received and staff can then follow up any shortfalls.</p>

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



The Regulation and Quality Improvement Authority

7th Floor, Victoria House  
15-27 Gloucester Street  
Belfast  
BT1 4LS

**Tel** 028 9536 1111  
**Email** [info@rqia.org.uk](mailto:info@rqia.org.uk)  
**Web** [www.rqia.org.uk](http://www.rqia.org.uk)  
 [@RQIANews](https://twitter.com/RQIANews)

Assurance, Challenge and Improvement in Health and Social Care