The Regulation and Quality Improvement Authority

Inspection Report

23 November 2023

Massereene Manor Residential Home

Type of service: Residential Care Home
Address: 6 Steeple Road, Antrim, BT41 1AF
Telephone number: 028 9448 7739

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: Hutchinson Homes Ltd **Responsible Individual:** Mrs Janet Montgomery	**Registered Manager:** Mr. Zoltan Csak – not registered
Person in charge at the time of inspection: Ms. Siobhan Brammald (Senior Care Lead), Mr. Zoltan Csak (Manager) arrived at 11.00am	**Number of registered places:** 8 A maximum of eight residential beds in category RC-DE. The home is also approved to provide care on a day basis to two persons
Categories of care: Residential Care (RC) DE – Dementia.	**Number of residents accommodated in the residential care home on the day of this inspection:** 8
Brief description of the accommodation/how the service operates: Massereene Manor Residential Home is a registered residential care home which provides health and social care for up to eight residents. Residents' bedrooms, the lounge and the dining room are all located over one floor. The home is under the same roof as Massereene Manor Nursing Home; the same manager manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 23 November 2023, from 9.45am to 12.00pm. This was completed by a pharmacist inspector. The inspection 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 area for improvement identified at the last care inspection is carried forward to be reviewed at the next care inspection.

Review of medicines management found that satisfactory arrangements were in place for the safe management of medicines.

Medicine records and medicine related care plans were mostly well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were mostly administered their medicines as prescribed. One area for improvement was identified in relation to personal medication records.

Whilst one area for improvement was 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 well led by the management team with respect to medicines management.

RQIA would like to thank the 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 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 and care plans and the auditing systems used to ensure the safe management of medicines. The inspector spoke with the manager and staff 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 the manager, the senior care lead and a senior care assistant.

Residents were observed to be relaxed and comfortable in the home. Staff were warm and friendly and it was obvious from their interactions that they knew the residents well and were aware of their likes/dislikes.

Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs.

Feedback methods included a staff poster and questionnaires which were provided to the manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, two questionnaires had been received by RQIA. The respondents indicated that they were very satisfied with all aspects of care.

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 18 July 2023		
Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 13 (1) (b) **Stated:** First time	The registered person shall ensure that residents who are deemed to be at risk of falls have a detailed falls care plan in place and a risk assessment completed after each fall.	**Carried forward to the next inspection**
	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.	

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 medical 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. However, in line with best practice, two staff members had not checked and signed the personal medication records when they were written and updated to state that they were accurate. 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 on 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 and a care plan directing the use of the medicine was in place. Staff knew how to recognise a change in a resident's behaviour and was aware that this change may be associated with pain or other factors. These medicines were infrequently used.

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?

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.

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 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.

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. The records were found to have been fully and accurately completed.

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 satisfactory arrangements in place for the management of controlled drugs.

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 medicines so that they could be easily audited. This is good practice.

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new residents or residents returning from hospital. Written confirmation of the resident's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

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.

Management and staff were familiar with the type of incidents that should be reported.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, one audit discrepancy was observed in the administration of a medicine. This was drawn to the attention of the manager and the senior care lead for corrective action.

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.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

One new area for improvement has been identified where action is required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	1*	1

* The total number of areas for improvement includes one which is carried forward for review at the next inspection.

The area for improvement and details of the Quality Improvement Plan were discussed with Mr. Zoltan Csak, Manager and Ms. Siobhan Brammald, Senior Care Lead, as part of the inspection process. The timescale for completion commences 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 13 (1) (b) **Stated:** First time **To be completed by:** With immediate effect (18 July 2023)	The registered person shall ensure that residents who are deemed to be at risk of falls have a detailed falls care plan in place and a risk assessment completed after each fall. **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.** Ref: 5.1
Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022	
Area for improvement 1 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 23 November 2023	The registered person shall ensure that two staff members verify and sign the personal medication records when they are written and updated to state that they are accurate. Ref: 5.2.1 **Response by registered person detailing the actions taken:** This has been reiterated wth all staff, outstanding signatures now in place and compliance will be monitored moving forward

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The Regulation and Quality Improvement Authority

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