The Regulation and Quality Improvement Authority

Inspection Report

24 June 2021

Milesian Manor Nursing Home

Type of service: Nursing Home
Address: 9 Ballyheifer Road, Magherafelt, BT45 5DX
Telephone number: 028 7963 1842

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: Macklin Care Homes Ltd **Responsible Individual:** Mr Brian Macklin	**Registered Manager:** Mr Anthony Curran **Date registered:** Acting
Person in charge at the time of inspection: Jenni Kitchener – Senior Nurse	**Number of registered places:** 46 Maximum of 22 patients in NH-DE Category. The home is also approved to provide care on a day to six persons on the first floor and two persons on the second floor.
Categories of care: Nursing (NH): DE – dementia PH(E) - physical disability other than sensory impairment – over 65 years PH – physical disability other than sensory impairment I – old age not falling within any other category	**Number of patients accommodated in the nursing home on the day of this inspection:** 39
Brief description of the accommodation/how the service operates: This is a nursing home which is registered to provide care for up to 46 patients. This home shares the same building as Milesian Manor Residential Care Home.	

2.0 Inspection summary

An unannounced inspection took place on 24 June 2021 between 10:30am and 2:30pm. The inspection was conducted by a pharmacist inspector.

This inspection focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified at the last medicines management inspection.

Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last care inspection would be followed up at the next care 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 we reviewed information held by RQIA about this home. This included previous inspection findings, incidents and correspondence. To complete the inspection we reviewed: 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.

4.0 What people told us about the service

We met with the senior nurse and two staff nurses. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff were warm and friendly and it was evident from their interactions that they knew the patients well. Patients were observed to be relaxing in lounges and bedrooms throughout the home.

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

In order to reduce footfall throughout the home, the inspector did not meet with any patients during the inspection. Feedback methods included a staff poster and paper questionnaires which were provided to the senior nurse for any patient 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 last inspection?

The last inspection to this nursing home was undertaken on 30 March 2021 by a care inspector. The last medicines management inspection was undertaken on 19 November 2018.

Areas for improvement from the last care inspection on 30 March 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 16 (2) (b) **Stated:** First time	The registered person shall ensure care plans for the management of challenging behaviour accurately reflect assessed patient need and any recommendations from the multidisciplinary team. Care plans should be written in keeping with the assessed needs of the patient. Daily progress notes should accurately record actions taken and conversations had with the multidisciplinary team in keeping with best practice guidance. **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.**	**Carried forward to the next inspection**
Area for improvement 2 **Ref**: Regulation 13 (7) **Stated:** First time	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the deficits highlighted in 6.2.4. **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.**	**Carried forward to the next inspection**
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for improvement 1 **Ref**: Standard 11	The registered person shall ensure the programme of activities is displayed in a suitable format in the home. Arrangements for	**Carried forward to the next inspection**

Stated: First time	the provision of activities should be in place in the absence of the lifestyle therapists. A contemporaneous record of activities delivered must be retained. Activities must be integral part of the care process and care planned for with daily progress notes reflecting activity provision. **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.**	
Area for improvement 2 **Ref:** Standard 12.25 **Stated:** First time	The registered person shall ensure that dignified clothing protectors are provided for patients who require this form of provision. **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.**	**Carried forward to the next inspection**
Area for improvement 3 **Ref**: Standard 4.9 **Stated:** First time	The registered person shall ensure identified patients monthly care plan reviews and daily evaluation records are meaningful and patient centred. All entries in the identified care records should be contemporaneous, signed, dated and timed. **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.**	**Carried forward to the next inspection**
Area for improvement 4 **Ref**: Standard 4.1 **Stated:** First time	The registered person shall ensure an initial plan of care based on the pre-admission assessment and referral information is in place within 24 hours of admission. The care plans should be further developed within five days of admission, reviewed and updated in response to the changing needs of the patient. **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.**	**Carried forward to the next inspection**

<table>
<tr><td rowspan="2">Area for improvement 5

Ref: Standard 21.1

Stated: First time</td><td>The registered person shall ensure care plans for the management of wounds accurately reflect recommendations of the multidisciplinary team. Care should be delivered in keeping with the assessed needs of the patient. Wound assessment and evaluations should be in keeping with best practice guidance.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>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.</td></tr>
<tr><td rowspan="2">Area for improvement 6

Ref: Standard 39.4

Stated: First time</td><td>The registered person shall ensure a system is developed to ensure compliance with mandatory training requirements. Updates in mandatory training should be delivered in a timely manner.</td><td rowspan="2">Carried forward to the next inspection</td></tr>
<tr><td>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.</td></tr>
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Areas for improvement from the last medicines management inspection on 19 November 2018		
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance summary**
Area for improvement 1 **Ref**: Standard 28 **Stated:** Second time	The registered person shall ensure that medicines not contained within the monitored dosage system are marked with the date of opening to facilitate audit. **Action taken as confirmed during the inspection**: Medicines not contained within monitored dosage systems were marked with the date of opening to facilitate audit.	**Met**
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time	The registered person shall ensure that the refrigerator temperature is monitored and recorded daily. **Action taken as confirmed during the inspection**: Medicines refrigerator temperatures were monitored and recorded on a daily basis.	**Met**

5.2 Inspection findings

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

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs will 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.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. 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 provide a double check that they were accurate.

Copies of patients' 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.

All patients 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.

Patients 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 patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available. Records of administration were clearly recorded. The reason for and outcome of administration were recorded in the daily progress notes.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required.

Some patients 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 patient 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 patient.

The management of thickening agents was reviewed for three patients. Care plans had not been fully updated to reflect the current speech and language therapist (SALT) assessment report. Staff were unable to locate the latest SALT assessment report for one patient. RQIA was assured at the time of inspection that the patient was receiving the correct diet and further assurances were sought and received post inspection to ensure this was correct. Records of prescribing and administration did not consistently detail the recommended consistency of fluids to be administered. An area for improvement was identified.

Medicines, such as warfarin and injectable medicines, including insulin are considered high risk medicines; therefore detailed care plans and written confirmation of medicine dosage regimes must be in place. There was evidence that care plans for high risk medicines were in place. The good practice of maintaining separate administration charts was acknowledged. However, obsolete warfarin regimes remained in the current folder. Prescribed warfarin doses were communicated to one member of staff by telephone. Any telephoned instructions should be

heard by two staff to ensure both have understood the dose. Transcribed warfarin regimes should also be signed by two members of staff. This was discussed and an area for improvement was identified.

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 patient'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 patients 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 patient could be easily located. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

The arrangements for the disposal of medicines were appropriate 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 patients 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. 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 senior nurse for ongoing close monitoring. The records were filed once completed and were readily retrievable.

The storage and administration of insulin was reviewed. In-use insulin pens were stored at room temperature. However, not all pens were individually labelled and the date of opening had not been recorded. This is necessary to facilitate audit and disposal at expiry. 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 receipt, administration and disposal of controlled drugs are recorded in a controlled drug record book. Robust arrangements were in place for the management of controlled drugs and records were maintained to the required standard.

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

The audits we completed at the inspection indicated medicines were being administered as prescribed.

The medicine cups used to administer medicines to patients were labelled as single use. Therefore, they should be discarded after each use. It was noted that some of the medicine cups were washed after use and then reused. Assurances were given that the necessary arrangements would be made to ensure that this practice is stopped.

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 was reviewed for two patients who had a recent hospital stay and were discharged back to this home. Hospital discharge letters had been received and a copy had been forwarded to the patients' GPs. The patients' personal medication records had been updated to reflect medication changes which had been initiated during the hospital stay. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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 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.

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.

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 patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has

a responsibility to check that staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff use.

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.

Records of staff training in relation to medicines management were available for inspection.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led.

The outcome of this inspection concluded that all areas for improvement identified at the last medicines management inspection had been addressed. Three new areas for improvement were identified in relation to the management of warfarin, insulin and thickening agents. Areas for improvement are detailed in the Quality Improvement Plan.

Whilst several areas for improvement were identified, RQIA is assured that overall the patients were being administered their medicines as prescribed.

We would like to thank the patients and staff for their assistance throughout the inspection.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with the Nursing Home Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes (2015).

	Regulations	Standards
Total number of Areas for Improvement	2*	9*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Jenni Kitchener, Senior Nurse, 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1	The registered person shall ensure care plans for the management of challenging behaviour accurately reflect

Ref: Regulation 16 (2) (b) **Stated:** First time **To be completed by:** Immediate action required	assessed patient need and any recommendations from the multidisciplinary team. Care plans should be written in keeping with the assessed needs of the patient. Daily progress notes should accurately record actions taken and conversations had with the multidisciplinary team in keeping with best practice guidance.
	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
Area for improvement 2 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. This area for improvement relates to the deficits highlighted in 6.2.4.
	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 Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 11 **Stated:** First time **To be completed by:** 30 April 2021	The registered person shall ensure the programme of activities is displayed in a suitable format in the home. Arrangements for the provision of activities should be in place in the absence of the lifestyle therapists. A contemporaneous record of activities delivered must be retained. Activities must be integral part of the care process and care planned for with daily progress notes reflecting activity provision.
	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. Ref: 5.1
Area for improvement 2 **Ref:** Standard 12.25 **Stated:** First time **To be completed by:** 30 April 2021	The registered person shall ensure that dignified clothing protectors are provided for patients who require this form of provision.
	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. Ref: 5.1

Area for improvement 3 **Ref**: Standard 4.9 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure identified patients monthly care plan reviews and daily evaluation records are meaningful and patient centred. All entries in the identified care records should be contemporaneous, signed, dated and timed.
	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. Ref: 5.1
Area for improvement 4 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure an initial plan of care based on the pre-admission assessment and referral information is in place within 24 hours of admission. The care plans should be further developed within five days of admission, reviewed and updated in response to the changing needs of the patient.
	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. Ref: 5.1
Area for improvement 5 **Ref**: Standard 21.1 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure care plans for the management of wounds accurately reflect recommendations of the multidisciplinary team. Care should be delivered in keeping with the assessed needs of the patient. Wound assessment and evaluations should be in keeping with best practice guidance.
	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. Ref: 5.1
Area for improvement 6 **Ref**: Standard 39.4 **Stated:** First time **To be completed by:** 30 April 2021	The registered person shall ensure a system is developed to ensure compliance with mandatory training requirements. Updates in mandatory training should be delivered in a timely manner.
	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. Ref: 5.1
Area for improvement 7 **Ref**: Standard 29 **Stated:** First time	The registered person shall ensure that nutritional care plans for residents prescribed a modified diet are reflective of the current SALT and IDDSI guidance. Records of prescribing and administration of thickening agents including the recommended consistency of fluids should be maintained

To be completed by: With immediate effect	Ref: 5.2.1
	Response by registered person detailing the actions taken: SALT assessments for all patients and the care plans have been reviewed to ensure that this has been completed for all patients, staff nurse training took place on 12th August 2021 to advise staff of same and the need to ensure that theses are kept up to date. this will be monitored by manager on a monthly basis
Area for improvement 9 **Ref**: Standard 29 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that updates to warfarin dosage regimes involve two members of staff. Obsolete warfarin dosage regimes should be removed from the current folder and archived appropriately. Ref: 5.2.1
	Response by registered person detailing the actions taken: We have again approached the GP surgery to have the warfarin results emailed to the home rather than phone, in the absense of this happening staff nurses have been advised to always have 2 staff available to take the prescription. Old regimes have been removed from the file
Area for improvement 9 **Ref**: Standard 30 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall review the management of insulin to ensure that: • each pen is labelled to denote ownership • the date of opening is recorded to facilitate audit and disposal at expiry Ref: 5.2.3
	Response by registered person detailing the actions taken: The pharmacist was contacted to ensure that all insulin pens are labelled and staff advised to ensure that date of openeing is recorded to facilitate the audit, this will be checked on the monthly drug audit

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