Inspection Report

30 May 2024

Madelayne Court

Type of service: Nursing Home
Address: Dunseverick & Dunluce Suites, 1-27 Nursery Avenue, Portstewart, BT55 7LG
Telephone number: 028 7083 1014

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Kathryn Homes Ltd **Responsible Individual** Mrs Tracey Anderson	**Registered Manager:** Mrs Jane Bell - not registered
Person in charge at the time of inspection: Mrs Jane Bell, Manager	**Number of registered places:** 48 This number includes: • a maximum of 22 patients in category NH-DE to be accommodated in the Dunseverick Suite • a maximum of 26 patients in categories NH-I, NH-MP(E) and NH-PH(E) to be accommodated in the Dunluce Suite • a maximum of 4 patients in category NH-TI. The home is also approved to provide care on a day basis for one person in the Dunseverick Suite.
Categories of care: Nursing Home (NH) I – old age not falling within any other category DE – dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years PH(E) - physical disability other than sensory impairment – over 65 years TI – terminally ill	**Number of patients accommodated in the nursing home on the day of this inspection:** 48
Brief description of the accommodation/how the service operates: Madelayne Court is a registered nursing home which provides nursing care for up to 48 patients. The home is divided in two units; the Dunseverick Suite located on the first floor which provides care for patients living with dementia; and the Dunluce Suite located on the second floor which provides general nursing care. There is a separately registered residential care 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 30 May 2024, from 10.00am to 2.00pm. 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.

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

Review of medicines management found that medicines were stored safely and securely. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines. The areas for improvement identified at the last medicines management inspection had been addressed. One new area for improvement was identified in relation to the administration of injectable medicines; details can be found in the quality improvement plan (QIP).

Whilst one area for improvement was identified, it was concluded that overall, with the exception of a small number of injectable medicines, patients were being administered their medicines as prescribed.

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 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. Discussions were held 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 briefly with two patients. The patients spoke positively of their experience of living in Madelayne Court and stated they were administered their medicines with dignity and at the correct time.

The inspector also met with nursing staff and the manager. Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well. 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.

Feedback methods included a staff poster and paper 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, one completed patient questionnaire had been received by RQIA. The respondent indicated they were administered their medicines at the correct time and that pain relief medicine was offered and administered if required.

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 12 February 2024		
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 29 **Stated:** First time	The registered person shall ensure that medicines receipt records are fully and accurately completed.	**Met**
	Action taken as confirmed during the inspection: Complete and accurate records of the receipt of medicines were maintained.	
Area for improvement 2 **Ref:** Standard 18 **Stated:** First time	The registered person shall review the management of distressed reactions to ensure that: • a care plan is in place to direct care • the reason for and outcome of administering the medicines is recorded.	**Met**
	Action taken as confirmed during the inspection: This area for improvement was assessed as met. See Section 5.2.1.	

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 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.

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 state 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.

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 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 the outcome. 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 distressed reactions was reviewed. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. Records included the reason for and outcome of each administration.

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. Care plans and pain assessments were in place and reviewed regularly.

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 and nutritional supplements were reviewed. 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.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside the recommended range. Staff were reminded to consistently record the date of opening on in-use insulin pen devices in order to facilitate audit and disposal upon expiry.

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 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. Temperatures of medicine storage areas were 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 patients 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.

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.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plans. Written consent and care plans were in place when this practice occurred.

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

The audits completed at the inspection indicated that the large majority of medicines were being administered as prescribed. However, discrepancies involving two injectable medicines prescribed to be administered at defined time intervals, were identified. This was brought to the attention of the manager on the day of the inspection who provided assurances that the discrepancies would be escalated to the prescriber for advice and guidance. A robust system for the management of injectable medicines must be implemented. This was discussed with the manager and nursing 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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient'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 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 the 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 they staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

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.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005.

	Regulations	Standards
Total number of Areas for Improvement	1	0

The new area for improvement and details of the Quality Improvement Plan were discussed with Mrs Jane Bell, Manager, 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** From the date of the inspection (30 May 2024)	The registered person shall ensure systems are reviewed to ensure injectable medicines are administered as prescribed. Ref: 5.2.3
	Response by registered person detailing the actions taken: New processes have been implemented as follows -Injectable medications diarised - Individual injectable medication chart in individual kardex's - Injectable medications audited monthly by HM/DHM - Due dates for injectable medications at the front of kardex folder

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The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

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

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