

# Inspection Report

16 May 2022



## St Macartans

Type of service: Nursing Home  
Address: 74 Main Street, Clogher, BT76 0AA  
Telephone number: 028 8554 8250

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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

<p><b>Organisation/Registered Provider:</b> Kilmorey Care Ltd</p> <p><b>Responsible Individual:</b> Mr Cathal O'Neill</p>	<p><b>Registered Manager:</b> Mrs Samantha Hackett</p> <p><b>Date registered:</b> 24 September 2020</p>
<p><b>Person in charge at the time of inspection:</b> Mrs Samantha Hackett</p>	<p><b>Number of registered places:</b> 33</p> <p>A maximum of eight patients in category NH-DE. A maximum of six persons accommodated within categories NH-LD/LD(E). The home is also approved to provide care on a day basis to one person in the dementia unit. There shall be one named resident receiving residential care in category RC-LD(E). One named patient receiving care on a day basis in category NH-I.</p>
<p><b>Categories of care:</b> Nursing Home (NH): I – old age not falling within any other category DE – dementia LD – learning disability. LD(E) – learning disability – over 65 year. PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years</p>	<p><b>Number of patients accommodated in the nursing home on the day of this inspection:</b> 29</p>
<p><b>Brief description of the accommodation/how the service operates:</b> St Macartans is a registered nursing home which provides nursing care for up to 33 patients. The home is divided into two units over four floors. Communal lounge and dining areas are located on the lower and ground floors.</p>	

## 2.0 Inspection summary

An unannounced inspection took place on 16 May 2022, from 9.40am to 1.50pm. 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 inspection.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. 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 and patients were administered their medicines as prescribed.

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 in relation 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. 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. Staff and patients views were also obtained.

## 4.0 What people told us about the service

To reduce footfall throughout the home, the inspector did not meet with any patients.

The inspector met with nursing 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 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, 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 8 March 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
<b>Area for improvement 1</b> <b>Ref:</b> Regulation 27(4)(d)(i) <b>Stated:</b> First time	The registered person shall ensure the practice of wedging open- fire safety doors is ceased.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> No fire safety doors were observed to be wedged open.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		Validation of compliance
<b>Area for improvement 1</b> <b>Ref:</b> Standard 44(1) <b>Stated:</b> First time	The registered person shall replace the missing ceiling tiles in the identified bathroom.	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> The missing ceiling tiles in the identified bathroom had been replaced.	

## 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 medical 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.

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 nurses 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 nurses 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 for two patients. Directions for use were clearly recorded on the personal medication records; care plans directing the use of these medicines were in place. The manager and nurse 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. The manager and nurse 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 was reviewed for two patients. 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.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained.

A care plan was in place when a patient required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was too low.

### **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 medicines 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, with one exception, medicines were available for administration when patients required them. The medicine that was not available arrived in the home during the inspection. The need to ensure that robust systems are in place to ensure doses are not missed was discussed with the manager.

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 patient 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 patients to ensure that they are receiving the correct prescribed treatment.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. However, audit discrepancies were observed in the administration of a couple of medicines. These discrepancies were discussed with the manager who gave an assurance that the medicines would be closely monitored as part of the ongoing audit activity.

A sample of the medicines administration records was reviewed. The records were found to have been completed in a satisfactory manner.

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 all medicines so that they could be easily audited. This is good practice. The merit of increasing the number of audits carried out on boxed medicines was discussed and a sample recording format was left with the manager for her consideration.

#### **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. 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.

The manager and nurse were familiar with the type of incidents that should be reported. There had been one medicine related incident reported to RQIA since 1 April 2020. There was evidence that the incident had been investigated and the learning shared with the nursing 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 are competent in managing medicines and that they 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. A written record was completed for induction and competency assessments.

Records of nurse training in relation to the administration of medicines via the enteral route were available for inspection.

## 6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
<b>Total number of Areas for Improvement</b>	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Samantha Hackett, Manager, as part of the inspection process and can be found in the main body of the report.



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