The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Mullaghboy

Provider: Mullaghboy Limited

Date of Inspection: 9 October 2025

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

1.0 Service information

Organisation:	Mullaghboy Limited
Responsible Individual:	Mr Robert Maxwell Duncan
Registered Manager:	Mrs Lesley Johnston, not registered
Service Profile: Mullaghboy is a registered nursing home which provides nursing care for up to 33 patients who require general nursing care, including patients living with a terminal illness. Patient bedrooms are located over two floors. Patients have access to communal spaces, a dining room and outdoor space.	

2.0 Inspection summary

An unannounced inspection took place on 9 October 2025 from 10.30am to 3.40pm. The inspection was completed by a pharmacist inspector and focused on medicines management within the home.

The inspection was undertaken to evidence how medicines are managed in relation to the regulations and standards and to determine if the home is delivering safe, effective and compassionate care and is well led in relation to medicines management. The areas for improvement identified at the last care inspection were carried forward for review at the next inspection.

Mostly satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered the majority of their medicines as prescribed. However, improvements were necessary in relation to the management of distressed reactions, the management of thickening agents and monitoring the temperature of the medicine storage areas.

Whilst areas for improvement were identified, there was evidence that with the exception of a small number of medicines, patients were being administered their medicines as prescribed.

Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, and new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

Patients were observed to be relaxed and comfortable in the home and in their interactions with staff. It was evident that staff knew the patients well.

RQIA would like to thank the staff for their assistance throughout the inspection.

3.0 The inspection

3.1 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 against the regulations and standards, 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 areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

3.2 What people told us about the service and their quality of life

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. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Staff advised that they were familiar with how each patient liked to take their medicines and medicines were administered in accordance with individual patient preference. Staff also said that they prioritised patients who required pain relief and time-critical medicines during each medicine round.

Eight questionnaires were received from patients or from relatives on their behalf, who were satisfied with how their medicines are managed. The service user questionnaires received, stated that patients felt they could discuss with staff any concerns they might have in regard to their medication. They stated that they had enough time to take their medication and medication is administered at the right time. In addition, that pain relief medication is offered if needed.

3.3 Inspection findings

3.3.1 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 a GP, a 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 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. A small number of minor discrepancies were highlighted for immediate corrective action and on-going vigilance.

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 etc.

The management of insulin was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records were well maintained. The audits completed indicated that medicines were administered as prescribed.

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 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 distressed reactions, was reviewed. Directions for use were clearly recorded on the personal medication record and patient-centred care plans 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 and other factors. However, records did not include the reason for and outcome of each administration. An area for improvement was identified.

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 were in place and reviewed regularly. However, one care plan needed updated to reflect the most recent prescribed medicine. This was discussed with the manager for immediate corrective action.

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. Speech and language assessment reports and care plans were in place. However, one personal medication record did not include the prescribed thickening agent and one did not include the recommended consistency level. Records of prescribing and administration, including the recommended consistency level must be maintained. An area for improvement was identified.

3.3.2 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.

Records reviewed 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 medicine 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. Medicine trolleys were securely locked; however, the temperature of all medicine storage areas were not being monitored daily. The temperature of the treatment room on the ground floor was monitored and recorded daily to ensure that medicines are stored appropriately. However, the temperature of the medicine trolley storage areas on the ground floor and the first floor were not monitored to ensure medicines are stored appropriately. An area for improvement was identified.

Satisfactory arrangements were in place for medicines requiring cold storage, the storage of controlled drugs and the safe disposal of medicines.

3.3.3 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 accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing monitoring. Records were filed once completed and were readily retrievable for audit/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 should be recorded in a controlled drug record book. Controlled drugs were observed to be administered as prescribed and records maintained to the required standard.

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 plan. Written consent and care plans were in place when this practice occurred.

Management and staff audited the administration of medicines on a regular basis within the home. The date of opening was recorded on medicines to facilitate audit and disposal at expiry. The manager asked for advice on expanding their current audit. Advice was provided and an audit tool was shared to aid development of a new audit.

3.3.4 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 at the time of admission or for patients returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

3.3.5 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.

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 small number of medicines. The audits were discussed in detail with the manager for on-going monitoring.

3.3.6 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 reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Medicines management policies and procedures were in place.

It was agreed that the findings of this inspection would be discussed with staff to facilitate the necessary improvements.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	1	5*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Lesley Johnston, 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 9 October 2025	The registered person shall ensure that the temperature of the medicine storage areas is monitored and recorded daily and that appropriate action is taken if the temperature recorded is over 25^{o}C. Ref: 3.3.2
	Response by registered person detailing the actions taken: Daily temperature checks of two additional medicine storage areas were commenced on 13/10/25 (On ground floor and first floor) Temperatures are recorded and have been consistently below 25 degrees celsius.
Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 18 **Stated:** First time **To be completed by:** 9 October 2025	The registered person shall review the management of distressed reactions to ensure that the reason for and outcome of each administration are recorded. Ref: 3.3.1
	Response by registered person detailing the actions taken: Following Inspection all Nursing staff were reminded of the importance of maintaining records for the administration for medicines prescribed for distressed reactions. Records are regularly checked by Nurse Manager - reason for and outcome of medication is now recorded.
Area for improvement 2 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 9 October 2025	The registered person shall review the management of thickening agents to ensure that records of prescribing and administration are accurately maintained. The recommended consistency level should be recorded on all records. Ref: 3.3.1
	Response by registered person detailing the actions taken: The management of thickening agents have been reviewed. Records of prescribing and administration are now being accurately maintained. Three residents are prescribed thickening agents - the recommended consistency level is now recorded on all records including Medicine Kardex and MARS.

Area for improvement 3 **Ref:** Standard 11 **Stated:** Second time **To be completed by:** 14 January 2025	The registered person shall make arrangements to ensure that staff are in such numbers to allow designated staff sufficient time to plan and deliver daily activities in order to provide structure to the patient's day. These should be developed in consultation with the patients and reviewed at least twice yearly to ensure this meets patients' changing needs. Individual activity assessments should be completed and reviewed as required to inform and compliment patient centred care plans. A contemporaneous record of activities delivered, the names of persons leading each activity and the patients who participate must be retained.
	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: 2.0
Area for improvement 4 **Ref:** Standard 11 **Stated:** Second time **To be completed by:** 14 January 2025	The registered person shall ensure that the programme of activities is displayed in a suitable format in an appropriate location in order that patients know what is scheduled.
	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: 2.0
Area for improvement 5 **Ref:** Standard 40 **Stated:** First time **To be completed by:** 14 January 2025	The registered person shall ensure staff have recorded individual supervision at least twice per year.
	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: 2.0

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