The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Kintullagh Care Home

Provider: Kathryn Homes Ltd

Date of Inspection: 25 March 2025

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:	Kathryn Homes Ltd
Responsible Individual:	Mrs Tracey Anderson
Registered Manager:	Miss Bronach Campbell, not registered
Service Profile: Kintullagh Care Home is a nursing home registered to provide nursing care for up to 61 patients. The home is divided into three units over two floors; the Willow and Beech units are on the ground floor, with the Oak unit located on the first floor. Patients have access to communal lounges, dining rooms and garden space.	

2.0 Inspection summary

An unannounced inspection took place on 25 March 2025, from 10.15am to 3.40pm. The inspection was completed by two pharmacist inspectors 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 inspection also reviewed the areas for improvement identified at the last medicines management inspection.

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

The area for improvement in relation to distressed reactions, identified at the last medicines management inspection was assessed as met. Details of the inspection findings, including areas for improvement carried forward for review at the next inspection, and the new area for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) (Section 4.0).

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

One visitor spoken with described the staff as 'brilliant' and praised the care in 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. 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. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

No completed questionnaires or responses to the staff survey were received following the inspection.

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.

Copies of patients' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

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. Records of administration included the reason for and outcome of each administration. One care plan needed updated with the details of the most recent prescribed medication, it was agreed that this would be reviewed and updated immediately following the inspection.

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 for the majority of patients and were reviewed regularly. A small number of care plans needed updated with the details of the latest prescribed medications. This was discussed with the manager for immediate 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. Records of prescribing and administration which included the recommended consistency level were maintained. One administration record needed the consistency level updated. This was discussed with the manager for immediate action.

The management of warfarin was reviewed. Warfarin is a high risk medicine which requires regular blood testing. The dose of warfarin prescribed depends on the blood test result. Records reviewed evidenced warfarin had been administered as prescribed. However, a small number of obsolete warfarin records had not been cancelled and archived. This was discussed with the manager for immediate action.

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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place the storage of controlled drugs.

Medicines which require cold storage must be stored between 2^{o}C and 8^{o}C to maintain their stability and efficacy. In order to ensure that this temperature range is maintained it is necessary to monitor the maximum and minimum temperatures of the medicines refrigerator each day and to then reset the thermometer. A review of records evidenced a small number of occasions where the refrigerator temperatures were recorded outside of this range and it was not clear that the thermometer was being reset. This was discussed for the manager for review and on-going monitoring.

The manager was reminded that medicines awaiting collection for disposal should be stored securely to prevent unauthorised access and collected in a timely manner.

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. Some handwritten medicine administration records

did not include the month or the year. This was discussed with 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 the controlled drug record book. It was acknowledged that mostly satisfactory arrangements were in place for the management of controlled drugs, however, on a small number of occasions reconciliation records had not been signed by two staff and the form of the controlled drug had not been recorded in the controlled drug record book. In addition, on one occasion the administration of a controlled drug had not been signed by a second member of staff and one controlled drug in Schedule 4, Part 1 had not been denatured prior to disposal. The manager should implement a robust audit system which covers all aspects of the management of controlled drugs. Action plans to address any shortfalls should be implemented and addressed. An area for improvement was identified.

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 management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits had been discussed with staff and addressed/ action plans had been implemented and addressed. The date of opening was recorded on the majority of medicines to facilitate audit and disposal at expiry. Staff were reminded that this should be recorded on all medicines.

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. There was evidence that any discrepancies had been followed up in a timely manner to ensure that the correct medicines were available for administration. 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 medicines were being administered as prescribed. A small number of minor discrepancies were discussed.

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 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.

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

An area for improvement has been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	3*	6*

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

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

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:** With immediate effect (25 March 2025)	The registered person shall implement a robust audit system which covers all aspects of the management of controlled drugs including those identified as this inspection. Any shortfalls identified should be detailed in an action plan and addressed.
	Response by registered person detailing the actions taken: A controlled drug audit has been added into the monthly medication audit to cover all aspects of controlled drugs. Nurses meeting held to discuss correct management of controlled drugs. Flash meetings which happen Monday- Friday with management, each unit has to bring the controlled drug book for it to be checked there are no missing signatures.
Area for improvement 2 **Ref:** Regulation 20 (1) (a) **Stated:** First time **To be completed by:** 9 June 2024	The registered person shall review the staffing arrangements in the home to include the levels of staff on duty; the deployment of staff and the working practices to ensure that the needs of patients are met. This is in particular reference to the morning routines and servings of breakfasts.
	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: 2.0
Area for improvement 3 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time **To be completed by:** 1 July 2024	The registered person shall ensure that the record keeping in relation to wound management is maintained appropriately and in accordance with legislative requirements, minimum standards and professional 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: 2.0
Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 38 **Stated:** First time	The registered person shall ensure all pre-employment checks are in place prior to the newly appointed staff member commencing in the post. This is stated in reference, but not limited to, gaps in employment and reasons for leaving previous employment.

To be completed by: 8 May 2024	
	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 2 **Ref:** Standard 41 **Stated:** First time **To be completed by:** 9 May 2024	The registered person shall ensure that robust arrangements are in place to ensure one to one care is provided at all times as required and breaks for staff providing this care are appropriately managed.
	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 3 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 9 July 2024	The registered person shall ensure that pressure management care plans, for those patients who require to be repositioned accurately reflect the required frequency for this care.
	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 12 **Stated:** First time **To be completed by:** 9 July 2024	The registered person shall ensure patients are afforded a choice of where to be seated for their meals.
	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 12 **Stated:** First time **To be completed by:** 9 July 2024	The registered person shall ensure that food intake records are reflective of the actual food consumed by patients and include the snacks taken between meal times.
	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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