



The Regulation and
Quality Improvement
Authority

Inspection Report

Name of Service: Mahon Hall
Provider: Ann's Care Homes
Date of Inspection: 3 April 2025

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

1.0 Service information

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| Organisation /Registered Provider: | Ann's Care Homes |
| Responsible Individual | Mrs Charmaine Hamilton |
| Registered Manager: | Ms Cristina Citea (not registered) |
| <p>Service Profile: Mahon Hall is a registered nursing home which provides general nursing care for up to 44 patients. There are a range of communal areas throughout the home.</p> <p>There is a separate registered residential care home which occupies the same building and the manager for this home manages both services.</p> | |

2.0 Inspection summary

An unannounced inspection took place on 3 April 2025, from 10.00am to 3.10pm. 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. 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 the majority of medicines were administered as prescribed. However, improvements were necessary in relation to the administration of inhalers and liquid medicines.

Whilst an area for improvement was 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 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).

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

Three questionnaires were received from patients who were very satisfied with how their medicines were managed. Comments included: "They are all very kind." and "They ask am I ok." Responses from patients confirmed they are given enough time to take their medicines and that they get their medicines at the right time.

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.

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.

One patient's personal medication record listed an ongoing medicine which did not have a record of administration for the past month, this was highlighted to the nurse in charge to investigate and report to RQIA. The outcome of the investigation was that the medicine was on hold. The manager was reminded that medicines which are on hold or stopped by prescribers should be updated in the personal medication record to reflect this.

The majority of 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. However, a small number of records were missing the date of writing this was highlighted for immediate corrective action and on-going vigilance.

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 distressed reactions, pain, thickening agents, insulin and epilepsy 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.

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. Blood tests had been carried out at the identified times and warfarin had been administered as prescribed, a patient specific care plan was in place. The manager was reminded that two staff members should verify the details and sign when the transcribing of warfarin regimens occurs.

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. The temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. 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 second verification 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 the controlled drug record book. One entry for destruction of a controlled drug which was accurately recorded in the controlled drug record book had not been entered in the disposal book. The manager agreed to discuss with staff and monitor closely.

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 action plans had been implemented and addressed. The date of opening was recorded on medicines to facilitate audit and disposal at expiry.

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 liquid medicines and inhalers. The audits were discussed in detail with the nurses on duty and the manager for on-going monitoring. An area for improvement was identified.

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 the majority of 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.

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 ongoing improvement.

4.0 Quality Improvement Plan/Areas for Improvement

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

| | Regulations | Standards |
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| Total number of Areas for Improvement | 1* | 4* |

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

This inspection resulted in one new area for improvement being identified. Findings of the inspection were discussed with Ms Cristina Citea, Manager and the regional manager, as part of the inspection process and can be found in the main body of the report. The timescales for completion commence from the date of inspection.

| Quality Improvement Plan | |
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| Action required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 | |
| Area for improvement 1 Ref: Regulation 14 (2) (a) Stated: First time To be completed by: 26 November 2024 | The registered person shall ensure as far as reasonably practical that all parts of the home to which patients have access are free from hazards to their safety. 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 28 Stated: First time To be completed by: 3 April 2025 | The registered person shall ensure that liquid medicines and inhalers are administered in accordance with the prescriber's instructions Ref: 3.3.3 Response by registered person detailing the actions taken: The registered manager has completed supervision with nursing staff to reiterate the importance of ensuring that prescribers instructions are adhered to when administering liquid medications and inhalers. Compliance will be monitored during medication auditing. |
| Area for improvement 2 Ref: Standard 41.1 Stated: First time To be completed by: 31 December 2024 | The registered person shall review staffing arrangements to ensure that there are adequate staff on duty to meet the assessed needs of patients. This review should take account of but is not limited to dependencies of patients as stated within care plans. 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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| <p>Area for improvement 3</p> <p>Ref: Standard 37</p> <p>Stated: First time</p> <p>To be completed by: 26 November 2024</p> | <p>The registered person shall ensure that patients' confidential records are securely stored.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p> |
| <p>Area for improvement 4</p> <p>Ref: Standard 4</p> <p>Stated: First time</p> <p>To be completed by: 31 December 2024</p> | <p>The registered person shall ensure that care plans regarding personal hygiene are person centred and reflect the current needs of the patients.</p> <hr/> <p>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.</p> <p>Ref: 2.0</p> |

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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



Twitter: @RQIANews