The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: St Macartans

Provider: Kilmorey Care Ltd

Date of Inspection: 1 August 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:	Kilmorey Care Ltd
Responsible Individual:	Mr Cathal O'Neill
Registered Manager:	Mrs Veronica McElmurry
Service Profile: St Macartans is a nursing home registered to provide nursing care for up to 33 patients, including one named resident living with a learning disability, aged over 65 years of age, receiving residential care. The home is also approved to provide care on a day basis to one person in the dementia unit. The home is divided into two units and has bedroom accommodation over four floors. Patients have access to communal lounges, dining rooms and outdoor spaces.	

2.0 Inspection summary

An unannounced inspection took place on 1 August 2025, from 10.30am to 2.45pm. 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. Most 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. However, improvements were necessary in relation to medicine administration records, records of disposal and the management of controlled drugs.

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.

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.

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).

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 questionnaire was received from a patient who was satisfied with how their medicines were managed.

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.

RQIA did not receive any responses to the staff survey 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. One minor discrepancy was brought to the attention of the nurse in charge for immediate updating.

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 pain and specialist medicines were 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. Review of records of administration indicated that these medications were used infrequently.

The nurses were reminded that the reason for and outcome of each administration should be recorded.

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 which included the recommended consistency level were maintained. Administration records reviewed contained the number of scoops of thickening agent required; these should reflect the recommended consistency level. This was discussed with the nurses for immediate correction.

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 of the recommended range. One in use insulin pen was labelled, but did not have the date of opening recorded, although it was clear from records it had not been used after the expiry date. This was discussed with the nurses for immediate action and on-going monitoring.

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 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. 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 and the storage of controlled drugs.

The nurse in charge was reminded that medicines awaiting collection for disposal should be stored securely to prevent unauthorised access and collected in a timely manner. A review of records of disposal evidenced that the date of disposal was not consistently recorded and there were no records of disposal for three controlled drugs. See also section 3.3.3. An area for improvement was identified.

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 medicine administration records was reviewed. Most of the records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review. A significant number of medicine administration records generated by staff in the home had not been checked and signed by two staff members to verify that they were accurate and some did not include the quantity of medication received into the home. An area for improvement was identified.

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. A significant number of pages in the controlled drug record book were not completed fully and accurately. The patient's full name had not been recorded and some balances had not been brought to zero when medication was recorded as destroyed. There were three pages in the controlled drug record book in which the disposal of controlled drugs had not been recorded nor had they been recorded in the record of disposal book. It was confirmed post inspection that these controlled drugs had not been denatured prior to disposal. See also section 3.3.2. 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. One care plan was needed for the crushing of medicines. This was discussed with nurses for immediate action.

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. The date of opening was usually recorded on medicines to facilitate audit and disposal at expiry.

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 medicines were being administered as prescribed.

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

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	3*	2*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with the deputy 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:** 1 August 2025	The registered person shall review the management of controlled drugs to ensure that controlled drugs are denatured prior to disposal and the controlled drug record book is accurately maintained. Ref: 3.3.2 & 3.3.3
	Response by registered person detailing the actions taken: Supervision has been provided to all nursing staff regarding the denaturing of controlled medications prior to them leaving the building, in addition a supervision has been provided regarding the recording in the CD and disposal books.
Area for improvement 2 **Ref:** Regulation 13 (4) **Stated:** First time **To be completed by:** 1 August 2025	The registered person shall ensure that medicine administration records generated in the home are checked and signed by two trained staff members to verify accuracy. Ref: 3.3.3
	Response by registered person detailing the actions taken: The Kardex and MARS are both generated trought our Goldcrest system by the nurse on duty at that time. It is current policy for the kardex to be verified by a second nurse and both to sign the document. These two signatures will also now be applied to each patients MARS as they are printed.
Area for improvement 3 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 2 July 2024	The registered person shall ensure that the infection and control (IPC) issues identified during inspection are addressed with ongoing monitoring to ensure sustained compliance.
	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

<table>
<tr><th colspan="2">Action required to ensure compliance with the Care Standards for Nursing Homes, December 2022</th></tr>
<tr><td>Area for improvement 1

Ref: Standard 29

Stated: First time

To be completed by:
1 August 2025</td><td>The registered person shall ensure that records of disposal are accurately maintained to ensure a clear audit trail and include the date of disposal.

Ref: 3.3.2 & 3.3.3</td></tr>
<tr><td></td><td>Response by registered person detailing the actions taken:
Nurses have been reminded to maintain accurate records in the return book to the Pharmacist, a supervision was also given.</td></tr>
<tr><td>Area for improvement 2

Ref: Standard 38.3

Stated: First time

To be completed by:
2 July 2024</td><td>The registered person shall ensure that staff are recruited in accordance with relevant statutory employment legislation and mandatory requirements.

With specific reference to ensuring that:
• Any gaps in employment are explored and explanations recorded
• A pre-employment health assessment is obtained prior to commencing employment</td></tr>
<tr><td></td><td>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</td></tr>
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