Inspection Report

2 July 2024

Milesian Manor Residential Home

Type of service: Residential Care Home
Address: 9 Ballyheifer Road, Magherafelt, BT45 5DX
Telephone number: 028 7963 1842

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: Macklin Care Homes Ltd **Responsible Individual:** Mr Brian Macklin	**Registered Manager:** Mrs Julie Wallace **Date registered:** 13 January 2020
Person in charge at the time of inspection: Mrs Julie Wallace	**Number of registered places:** 32 There shall be a maximum of 32 residents in category RC-DE. The home is also approved to provide care on a day basis to 2 persons in category RC-DE on the Ground Floor and 2 persons in category RC-I on the Second Floor.
Categories of care: Residential Care (RC) DE – Dementia.	**Number of residents accommodated in the residential care home on the day of this inspection:** 32
Brief description of the accommodation/how the service operates: Milesian Manor Residential Home is a registered residential care home which provides health and social care for up to 32 residents. The home is divided in two units over two floors. Lime Tree on the first floor is an eight bedded all male unit and Oak Leaf on the ground floor is a 24 bedded unit for both males and females. Residents' bedrooms all have ensuite facilities. Residents have access to communal lounges and dining rooms and an enclosed garden area. There is a nursing home which occupies the same building with a separate registered manager.	

2.0 Inspection summary

An unannounced inspection took place on 2 July 2024, from 9.45am to 2.00pm. This was completed by a pharmacist inspector and 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.

The areas for improvement identified at the last care inspection have been carried forward for review at the next care inspection.

Review of medicines management found that medicines were stored securely. Medicine related care plans were well maintained and there were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed. One new area for improvement in relation to the accurate completion of handwritten medicine administration records was identified. Details of the area for improvement are included in the quality improvement plan (QIP).

Whilst one new area for improvement was identified, RQIA can conclude that overall, the residents were being administered their medicines as prescribed.

RQIA would like to thank the staff and residents for their assistance during 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 they were 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. Discussions took place with staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with senior care staff, care staff and the manager. Staff interactions with residents were warm, friendly and supportive. It was evident that they knew the residents well.

Staff expressed satisfaction with how the home was managed. They said that they had the appropriate training to look after residents and meet their needs.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any resident 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 22 April 2024		
Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022) (Version 1:2)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 24.2 **Stated:** Second time	The registered person shall ensure that all staff have formal recorded supervision no less than every six months. **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.**	**Carried forward to the next inspection**
Area for improvement 2 **Ref:** Standard 5.5 **Stated:** First time	The registered person shall ensure that risk assessments reflect residents' preferences and abilities with regards to the use of call bell leads in their bedrooms. **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.**	**Carried forward to the next inspection**
Area for improvement 3 **Ref:** Standard 35.7 **Stated:** First time	The registered person shall ensure that all staff are aware of the importance of hand hygiene and that staff carryout effective hand hygiene measures at appropriate 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.**	**Carried forward to the next inspection**

5.2 Inspection findings

5.2.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Residents in care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times the residents' 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.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. 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 state that they were accurate.

Residents 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 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 staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the resident's distress and if the prescribed medicine is effective for the resident.

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 records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a resident'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. Staff advised that they were familiar with how each resident expressed their pain and that pain relief was administered when required. Care plans were in place and reviewed regularly.

Some residents 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 resident 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 resident.

The management of thickening agents was reviewed. 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.

Care plans were in place when residents required insulin to manage their diabetes. Insulin was administered by the district nurse; records of the administration of insulin were available for review.

5.2.2 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 resident'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.

The records inspected showed that medicines were available for administration when residents required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each resident could be easily located. Medicines must be stored at the manufacturers' recommended temperature (at or below 25^{o}C) to maintain their efficacy and stability. The temperature of the medicine storage areas was monitored and recorded each day. However, it was identified that recent temperature recordings of the medicines storage room in the Oak Leaf unit were consistently above 25^{o}C. This was discussed with the manager who stated the issue had been escalated prior to the inspection and the home were awaiting work to be undertaken by the maintenance department. Assurances were provided that corrective action was imminent.

Satisfactory arrangements were in place for the safe disposal of medicines. Staff were reminded that medicines awaiting disposal should be stored securely to prevent unauthorised access.

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 residents to ensure that they are receiving the correct prescribed treatment.

Within the home, the administration of medicines is recorded on pre-printed or handwritten medicine administration records (MARs). A sample of the MARs were reviewed. Most of the records were found to have been fully and accurately completed. However, it was identified that a number of handwritten MARs did not contain all of the necessary information. The month and year was not recorded on some of the records reviewed and some did not state the residents name the record related to. The large majority of handwritten MARs were not checked and verified by two staff members; this is necessary to ensure accuracy. 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. 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 the large majority of medicines not supplied in the monitored dosage system so that they could be easily audited. This is good practice.

The audits completed at the inspection indicated that the medicines were being administered as prescribed.

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.

The management of medicines for residents who had a recent hospital stay and were discharged back to this home was reviewed. Hospital discharge letters had been received and a copy had been forwarded to the resident's GP. The residents' personal medication records had been updated to reflect medication changes which had been initiated during the hospital stay. Medicines had been accurately received into the home and administered in accordance with the most recent directions. There was evidence that staff had followed up any discrepancies in a timely manner to ensure that the correct medicines were available for administration.

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.

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 learning shared with 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 residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and they are supported. Policies and procedures should be up to date and readily available for staff.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff. Medicines management policies and procedures were in place and readily accessible to staff.

6.0 Quality Improvement Plan/Areas for Improvement

One new area for improvement has been identified where action is required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	0	4*

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

The new area for improvement and details of the Quality Improvement Plan were discussed with Mrs Julie Wallace, Registered Manager, as part of the inspection process. The timescale for completion commences from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Residential Care Homes Minimum Standards, December 2022	
Area for Improvement 1 **Ref:** Standard 24.2 **Stated:** Second time **To be completed by:** From the date of inspection (22 April 2024)	The registered person shall ensure that all staff have formal recorded supervision no less than every six months. **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: 5.1
Area for improvement 2 **Ref:** Standard 5.5 **Stated:** First time **To be completed by:** 31 July 2024	The registered person shall ensure that risk assessments reflect residents' preferences and abilities with regards to the use of call bell leads in their bedrooms. **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: 5.1
Area for improvement 3 **Ref:** Standard 35.7	The registered person shall ensure that all staff are aware of the importance of hand hygiene and that staff carryout effective hand hygiene measures at appropriate times.

Stated: First time **To be completed by:** From the date of inspection (22 April 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: 5.1
Area for improvement 4 **Ref:** Standard 31 **Stated:** First time **To be completed by:** From the date of inspection (2 July 2024)	The registered person shall ensure that all handwritten entries on medication administration records contain all of the necessary information and are verified and signed by two trained staff to ensure accuracy. Ref: 5.2.3
	Response by registered person detailing the actions taken: Discussed with staff. Further pharmacy training completed on 23/07/2024 which included this.

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