The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Maryland Healthcare Care Centre of Distinction

Provider: Maryland Healthcare Limited

Date of Inspection 8 January 2026

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:	Maryland Healthcare Limited
Responsible Individual:	Mrs Susan McCurry
Registered Manager:	Mrs Jacqueline Grace Woods

Service Profile:
Maryland Healthcare Care Centre of Distinction is a nursing home registered to provide general nursing care for up to 86 patients under and over 65 years of age, including patients living with dementia or a terminal illness. The home also provides care for patients living with a physical disability other than sensory impairment over and under the age of 65 years.

The home is a single storey building which is divided into four units; Maple, Larch, Juniper and Rowan. Patients have access to various communal spaces including lounges and gardens.

2.0 Inspection summary

An unannounced inspection took place on 8 January 2026, from 10am to 4.10pm. 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 area for improvement identified at the last care inspection was carried forward for review at the next inspection. The inspection also reviewed the areas for improvement identified at the last medicines management inspection.

The outcome of this inspection indicated that robust arrangements were not in place for some aspects of medicines management. Areas for improvement were identified in relation to the maintenance of the controlled drug record book, records for the disposal of medicines, the management of interim changes and the monitoring and recording of medicine refrigerator temperatures.

Whilst areas for improvement were identified, there was evidence that the majority of medicines were administered as prescribed.

Following the inspection, the findings were discussed with the senior pharmacist inspector in RQIA. It was decided that the home would be given a period of time to implement the

necessary improvements. A further medicines management inspection will be undertaken to determine if the necessary improvements have been implemented and sustained. Failure to implement and sustain the improvements may lead to enforcement.

The areas for improvement in relation to ensuring that the use of electronic medicine records are fully and accurately maintained and the management of warfarin, identified at the last medicines management inspection were assessed as met.

Details of the inspection findings, including the area for improvement carried forward for review at the next inspection, and the 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. They stated medication rounds were tailored to respect each individual's preferences, needs and timing requirements.

RQIA did not receive any completed questionnaires or 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 for a small number of patients were not up to date with the most recent prescription. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. This was discussed with staff and the manager for immediate corrective action and ongoing monitoring. Medicines were being administered as currently prescribed.

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 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.

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, the records for one patient did not include the reason for and outcome of each administration. This was discussed with staff and the manager for immediate corrective action ongoing monitoring.

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 and nutritional supplements was reviewed. Speech and language assessment reports and care plans were in place. However, not all the records of administration reviewed included the recommended consistency level. Records of prescribing and administration, including the recommended consistency level must be maintained. This was discussed with staff and the manager who agreed to record the consistency level on administration records following the inspection. Staff confirmed that thickening agents were being administered in accordance with recommendations.

There were currently no patients prescribed warfarin. However, the management of warfarin was discussed in detail with staff. Assurances were provided, that a robust system is in place for the management of warfarin should it be prescribed.

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 medicine doses had been omitted on one occasion, as the medicines were not available in the home. This had been escalated to management for immediate action and investigation to prevent a recurrence. Medicines must be available for administration as prescribed. This was discussed with the manager for ongoing monitoring. All medicines were available for administration as prescribed on the day of inspection.

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 for the storage of controlled drugs and the storage of medicines awaiting collection for disposal.

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. In one unit, over the previous three months the recorded temperatures were outside of the recommended maximum and minimum range.

Although this had been escalated, corrective action had not been taken. 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 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. Records were no longer being maintained electronically.

Review of the records of disposal indicated that they were not being accurately maintained on all occasions. Records of disposal must be accurately maintained to provide a clear audit trail. An area for improvement was identified.

The management of medication changes was reviewed. For one patient, following a medication change, staff were removing a discontinued medicine from their monitored dosage system each evening. This practice is unsafe. Robust systems must be in place for the management of medication changes. An area for improvement was identified. In addition, records of disposal were not maintained, see above.

Controlled drugs are medicines, which are subject to strict legal controls and legislation. They commonly include strong painkillers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. Each controlled drug formulation must have a separate entry in the controlled drug record book. The balance of two different formulations of the same controlled drug had been merged. This was discussed with staff and the manager and 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. The date of opening was recorded on medicines to facilitate audit and disposal at expiry. It was agreed that the areas for improvement identified at this inspection would be included in the audit process.

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 nurses on duty and 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 Standards.

	Regulations	Standards
Total number of Areas for Improvement	0*	5*

* the total number of areas for improvement includes one, which was carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Jacqueline Grace Woods, Registered Manager and senior management 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 Care Standards for Nursing Homes, December 2022	
Area for improvement 1 **Ref:** Standard 30 **Stated:** First time **To be completed by:** 8 January 2026	The registered person shall ensure that appropriate action is taken when refrigerator temperatures are outside the recommended range. Ref: 3.3.2
	Response by registered person detailing the actions taken: New drug fridge purchased and in place in Juniper unit trreatment room , temperatures recorded min and maximum
Area for improvement 2 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 8 January 2026	The registered person shall ensure that records of disposal are accurately maintained. Ref: 3.3.3
	Response by registered person detailing the actions taken: All units have a Drugs for destruction book which is in use
Area for improvement 3 **Ref:** Standard 28 **Stated:** First time **To be completed by:** 8 January 2026	The registered person shall ensure that safe systems are in place for the management of medication changes. Ref: 3.3.3
	Response by registered person detailing the actions taken: Any changes made by a GP mid month , pillpack will returned back to the pharmacy for the pillpack to be updated with correct medication .
Area for improvement 4 **Ref:** Standard 31 **Stated:** First time **To be completed by:** 8 January 2026	The registered person shall ensure that the controlled drug record book is accurately maintained. Ref: 3.3.3
	Response by registered person detailing the actions taken: CD administration book and CD count book in place in all 4 units. Any changes to CD,S e.g from tablet to liquid form will be recorded on separate page

Area for improvement 5 **Ref**: Standard 37 **Stated:** First time **To be completed:** From the date of inspection 26 & 27 November 2024	The registered person shall ensure that any record retained in the home which details patient information is stored safely and in accordance with DHSSP policy, procedures and guidance and best practice standards.
	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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