Inspection Report

28 February 2023

Cornfield Care Centre

Type of Service: Nursing Home
Address: Green Lane and Castle Lane Suites, 51a Seacoast Road, Limavady, BT49 9DW
Telephone number: 028 7776 1300

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: Cornfield Care Centre **Responsible Individual:** Mr Marcus Jervis Nutt	**Registered Manager:** Mrs Claire Gormley **Date registered:** 13 January 2017
Person in charge at the time of inspection: Mrs Claire Gormley	**Number of registered places:** 52 Comprising a maximum of 26 patients in categories NH-I, NH-PH and NH-PH(E) accommodated within the general nursing unit and a maximum of 26 patients in category NH-DE accommodated within the dementia unit. The home is also approved to provide care on a day basis to two persons.
Categories of care: Nursing (NH): I – old age not falling within any other category DE – dementia PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 49
Brief description of the accommodation/how the service operates: Cornfield Care Centre is a registered nursing home, which provides nursing care for up to 52 patients. The home is divided in two units over one ground floor level. One unit provides care for patients living with dementia and the other unit provides care under the general category of nursing care. The home shares the same site as another nursing home which shares the same senior management team.	

2.0 Inspection summary

An unannounced inspection took place on 28 February 2023, from 10.30am to 3.25pm. 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 outcome of this inspection resulted in one area for improvement being identified, detailed in the quality improvement plan. This relates to ensuring systems are in place so that medicines are disposed of once expired.

Whilst an area for improvement was identified, it was concluded that the patients were being administered their medicines as prescribed. Medicine records and medicine related care plans were well maintained.

RQIA would like to thank the staff and management for their assistance throughout 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. The inspector also spoke to 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 four nurses, the manager and the operations manager. Staff interactions with patients were warm, friendly and supportive and it was evident that staff knew patients well.

The staff spoken with expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and that management were available to discuss any issues and concerns should they arise.

Feedback methods included a staff poster and paper questionnaires which were provided for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no responses had been received.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

The last inspection to the nursing home was undertaken on 20 October 2022 by a care inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 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 the GP, the 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 at the inspection 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. It was agreed that one inaccuracy on a personal medication record, regarding a prescribed fluid consistency, would be corrected following the inspection.

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

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.

Medicine related care plans were in place for example for pain, distressed reactions, modified diets and insulin. Other appropriate care plans were in place, for example, the management of Parkinson's. When medicines were administered on a 'when required' basis for the management of distressed reactions, the reason for and the outcome of administration was recorded.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

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 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.

The records inspected 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 temperature of the medicine storage areas was monitored and recorded. Medicines refrigerators and controlled drugs cabinets were available for use as needed. In the Green Lane Suite, although current temperatures were satisfactory, maximum and minimum refrigerator temperatures were not being recorded since the thermometer on the new refrigerator did not have this facility. It was agreed that this would be addressed following the inspection.

Several expired medicines were observed to be available for use in the Green Lane Suite. Most of these were prescribed for use 'when required' and there was no evidence these had been administered following their expiry. However, one medicine had been put into use several months after the expiry date and had been administered daily since. These medicines were replaced immediately. A regular system of date checking must be in place e.g. at the start of each monthly medication cycle, to ensure that medicines are within their expiry date. An area for improvement was identified.

Satisfactory arrangements were in place for the disposal of medicines.

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

A sample of medication administration records was reviewed and was found to have been accurately completed. The records were filed once completed and were readily retrievable for audit.

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 a controlled drug record book. There were mostly satisfactory arrangements in place for the management of controlled drugs. Staff were advised that tapentadol is a Schedule 2 controlled drug and must be recorded in the main controlled drugs record book, this was an oversight and was implemented immediately. It had been recorded in a separate record, which was maintained in Cornfield for other controlled drugs and this record was accurate and up to date.

A range of audits were carried out during the inspection which indicated that medicines were administered as prescribed. The date of opening was recorded on the majority of medicines so that they could be easily audited.

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.

A review of records indicated that satisfactory arrangements were in place to manage medicines for patients new to the home or returning from hospital. Written confirmation of the medicine regimes was obtained at or prior to admission and details shared with the GP/community pharmacy as necessary. Medicine records had been accurately completed.

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 audited medicine administration on a regular basis within the home. A range of audits were carried out and those examined indicated generally satisfactory outcomes and included an action plan and evidence this was being followed up. It was agreed that the areas highlighted for attention in this report would be included within audit procedures to ensure they are embedded in practice.

Management and staff were familiar with the type of incidents that should be reported. No medicine related incidents had been reported to RQIA since the last inspection.

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 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 nurses responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

One area for improvement has been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005.

	Regulations	Standards
Total number of Areas for Improvement	1	0

The area for improvement and details of the Quality Improvement Plan were discussed with Mrs Claire Gormley, 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 Nursing Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure that a regular system of date checking is in place to ensure that medicines are not administered after their expiry date. Ref: 5.2.2
To be completed by: Immediately and ongoing (28 February 2023)	**Response by registered person detailing the actions taken**: Supervision completed with all nursing staff in relation to the importance of date checking of medication prior to administration. All nursing staff have completed an update on online medication awareness. Staff checklist has been updated for further checks to be completed of medication on the trolley and stock at each medication cycle. Regular audits remain ongoing.

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The Regulation and Quality Improvement Authority

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