Inspection Report
17 November 2020

Cove Manor

Type of Home: Residential Care Home
Address: 89 Mullanahoe Road, Ardboe, Dungannon, BT71 5AU
Tel No: 028 8673 6424
Inspector: Judith Taylor

This inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a residential care home which is registered to provide care for up to 14 residents. It is situated in the same building as Cove Manor nursing home.

2.0 Service details

Organisation/Registered Provider: Cove Manor Care Home Ltd **Responsible Individual:** Mr Sean McCartney	**Registered Manager and date registered:** Mrs Madge Quinn 19 December 2018
Person in charge at the time of inspection: Mrs Madge Quinn	**Number of registered places:** 14 Includes four named residents in category RC-MP
Categories of care: Residential Care (RC): I – old age not falling within any other category PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years MP – mental disorder excluding learning disability or dementia	**Total number of residents in the residential care home on the day of this inspection:** 14

3.0 Inspection focus

Following a risk assessment and to reduce the risk to residents during the pandemic outbreak, this inspection was carried out remotely.

This inspection was completed following a review of information requested and submitted to RQIA on 3 November 2020. This information included the completion of a self-assessment specific to medicines management in the home. Feedback was discussed with the manager on 17 November 2020.

This inspection focused on medicines management within the home and also assessed the progress made regarding the areas for improvement identified at the last medicines management inspection. Following discussion with the aligned care inspector, it was agreed that the areas for improvement identified at the last care inspection would be followed up at the next care inspection.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to residents' relatives by telephone
- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- reviewed documents to confirm that appropriate records were kept

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration
- medicine receipt and disposal
- care plans related to medicines management
- governance and audit arrangements for medicines management
- staff training and competency regarding medicines management
- medicine storage temperatures

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	1*	5*

*The total number of areas for improvement includes four that have been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan (QIP) were discussed with Mrs Madge Quinn, Registered Manager, and the deputy manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

5.0 What has this home done to meet any areas for improvement identified at the last medicines management inspection on (16 January 2019) and the last care inspection (22 October 2019)?

Areas for improvement from the last medicines management inspection		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 31 **Stated:** First time	The registered person shall ensure that two staff are involved in the transcribing of medicine details on medicine administration records.	**Met**
	Action taken as confirmed during the inspection: Handwritten entries on medicine records were signed by two staff.	
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time	The registered person shall develop the policies and procedures regarding the residential care home and in particular the disposal of medicines.	**Met**
	Action taken as confirmed during the inspection: Policies specific to the residential care home were in place. There had been some confusion regarding the differences in the disposal of medicines processes in residential care and nursing homes; advice was given. Assurances were provided that this would be clearly recorded and implemented from the inspection onwards. A revised policy was submitted to RQIA on 19 November 2020.	

6.0 What people told us about this home?

As part of the remote inspection process, we were provided with contact details of five residents' relatives. We were able to make contact with two relatives. The comments were very positive and complimentary regarding the care provision and the staff team.

Comments made included:

- "Look after xxx so well."
- "Staff are very good with the medicines."
- "No complaints at all; nice home, nice staff."
- "Know xxx really well and when needs assistance."
- "Madge is very good."

It was evident from discussions with the staff regarding the resident's care and medicines management, that they knew the residents well.

Feedback methods included a poster and online links to questionnaires which were provided to the registered manager for staff and any resident or their family representative to complete. At the time of issuing this report, six questionnaires had been received by RQIA; four from residents and two from relatives. All of the responses were positive, with the majority recorded as very satisfied with the care in the home. No staff had completed any questionnaires.

7.0 Inspection Findings

7.1 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 residents' needs will change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, a medical consultant or the pharmacist.

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

Three residents' personal medication records were reviewed. These are records used to list all the resident's 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 and/or hospital appointments. We noted that the majority of medicine entries and other information were accurately recorded; and in line with best practice, a second member of staff had checked and signed these personal medication records when they were written and updated, to ensure they were accurate. However, a few recording issues were noted and discussed. It was agreed that these records would be included in the audit process.

Copies of residents' 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 residents 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 pain and distressed reactions. Staff advised that all residents could tell staff if they were in pain. Staff were familiar with how each resident expressed their pain and/or distressed reaction and that prescribed medicines were administered when required. Care plans were in place for each resident and records of the reason for and outcome of any administration were maintained.

7.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines 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. A record of all incoming and outgoing medicines must be maintained.

Staff discussed the changes made in the ordering and stock control processes and advised that these were working well. They said they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

In relation to medicine storage, staff assured that these were stored safely and securely in the treatment room. This room is shared with Cove Manor Nursing Home. We were advised that there were safe arrangements to segregate residents and patients medicines, including controlled drugs. In relation to cold storage, the records of medicine refrigerator temperatures indicated that the thermometer was not reset each day. This is necessary to ensure that the refrigerator is working properly and that the medicines are being stored at the correct temperature for safe administration. An area for improvement was identified.

We reviewed the disposal arrangements for medicines. There was some confusion regarding the management of discontinued medicines in relation to residential care homes and nursing homes. However, this was resolved immediately following the inspection. See Section 5.0.

7.3 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, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed.

The governance arrangements for medicines management were examined. These are processes which when applied, assist with monitoring that residents are being administered their medicines, the medicine systems are working well; and enable identification of any deficits to be addressed. Management and staff audited medicine administration on a regular basis within the home. Audits focused on medicines not supplied in the monitored dosage system. The audit records showed some recording errors and the audits were limited to mostly tablets/capsules. These audits should include liquids, eye preparations and external preparations. See also Section 7.5. Staff confirmed that the date of opening was recorded on all medicines and any limited shelf life medicines, for example, eye preparations were replaced on or before the expiry date was reached.

7.4 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.

We reviewed the management of medicines for residents who were new to the home or had a recent hospital stay and were discharged back to this home. Hospital discharge letters had been received and a copy had been forwarded to the residents' 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. One medicine had not been recorded on the personal medication record; however, records of administration were in place. We were advised that this medicine had been discontinued since the documents were submitted to RQIA. The need for the personal medication records to be accurately written was reiterated.

7.5 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 helps staff to identify any medicine related incidents.

Following discussion, it was clear that management and staff were familiar with the type of incidents that should be reported.

There have been no medicine related incidents reported to RQIA since the home was registered in December 2018. However, the findings of this inspection indicate that the auditing system is not robust and hence incidents may not be identified. The need for a robust audit system which covers all aspects of medicines is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff. An area for improvement was identified.

7.6 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 that staff are supported. In addition, up to date policies and procedures must be in place and readily available for staff reference.

We were advised that all staff had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction, refresher training and competency assessments.

Policies and procedures were in place and updated following this inspection.

8.0 Evaluation of Inspection

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led with regard to the management of medicines.

We can conclude that overall that the residents were being administered their medicines as prescribed. The areas for improvement identified at the last medicines management inspection had been addressed. However, two new areas for improvement were identified in relation to storage and audit.

We would like to thank the relatives and staff for their assistance throughout the inspection.

9.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with Madge Quinn, Registered Manager and the deputy manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the residential care home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

9.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005 and the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011).

9.2 Actions to be taken by the home

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via the Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 21 (b) **Stated:** Second time **To be completed by:** 23 October 2019	The registered person shall ensure that: • The date is recorded when the Enhanced AccessNI disclosure is reviewed by the registered manager.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next inspection. Ref: 6.1
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 25.6 **Stated:** Second time **To be completed by:** 23 October 2019	The registered person shall ensure that the duty rota reflects the capacity of the staff working in the home.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next inspection. Ref: 6.1
Area for improvement 2 **Ref**: Standard 19.3 **Stated:** First time **To be completed by:** 23 October 2019	The registered person shall ensure that the Enhanced AccessNI disclosure certificate is stored in accordance with the AccessNI's code of practice.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next inspection. Ref: 6.1
Area for improvement 3 **Ref**: Standard 25.6 **Stated:** First time **To be completed by:** 23 October 2019	The registered person shall ensure that the duty rota accurately reflects the staff on duty in the home. The manager's hours should also be recorded.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next inspection. Ref: 6.2

Area for improvement 4 **Ref**: Standard 32 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall review the cold storage of medicines to ensure thermometer recordings are within range and the thermometer is reset every day. Ref: 7.2
	Response by registered person detailing the actions taken:
Area for improvement 5 **Ref:** Standard 30 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall develop a robust audit process which covers all aspects of medicines management. Ref: 7.3 & 7.5
	Response by registered person detailing the actions taken:

Please ensure this document is completed in full and returned via the Web Portal

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