Unannounced Post Registration Medicines Management Inspection Report
16 January 2019

Cove Manor

Type of service: Residential Care Home
Address: 89 Mullanahoe Road, Ardboe, Dungannon, BT71 5AU
Tel No: 028 8673 6349
Inspector: Judith Taylor

It should be noted that 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 the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a residential care home that provides care for up to 13 residents living with care needs as detailed in Section 3.0. This residential care home is located on the same site as Cove Manor nursing home.

3.0 Service details

Organisation/Registered Provider: Cove Manor Care Home Ltd **Responsible Individual:** Mr Sean McCartney	**Registered Manager:** Mrs Madge Quinn
Person in charge at the time of inspection: Ms Sarah Gildernew (Registered Nurse)	**Date manager registered:** 19 December 2018
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	**Number of registered places:** 13 including: category RC-MP for five identified residents only

4.0 Inspection summary

An unannounced inspection took place on 16 January 2019 from 14.00 to 16.30.

This was the post registration inspection in relation to medicines management in this newly registered residential care home, situated within Cove Manor Nursing Home. The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

This inspection was underpinned by 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).

Evidence of good practice was found in relation to training, medicines administration, the completion of most medicine records, and the safe storage of medicines.

Areas requiring improvement were identified in relation to the process for updating records and policies and procedures.

The residents and relative we met with spoke positively about the staff and the care provided. There was a warm and welcoming atmosphere in the home and the residents were observed to be relaxed and comfortable in their environment.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and residents experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	2

Details of the Quality Improvement Plan (QIP) were discussed with Mrs Madge Quinn, Registered Manager and Mr Sean McCartney, Responsible Individual, as part of the inspection process. The timescales for completion commence from the date of inspection.

4.2 Action/enforcement taken following the most the pre-registration inspection

No further actions were required to be taken following the most recent inspection on 8 May 2018. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the home was reviewed. This included the following:

- Recent inspection reports and returned QIPs.
- Recent correspondence with the home.
- The management of incidents: it was ascertained that no incidents involving medicines had been reported to RQIA since the home registered.

A poster was displayed to inform visitors to the home that an inspection by RQIA was being conducted.

During the inspection we met with one resident, one relative, two senior carers, the person in charge, the registered provider, two directors of the organisation and the registered manager who was in attendance for feedback at the end of the inspection.

We provided 10 questionnaires to distribute to residents and their representatives, for completion and return to RQIA and we asked management to display a poster which invited staff to share their views and opinions by completing an online questionnaire.

A sample of the following records was examined during the inspection:

- medicines received
- personal medication records
- medicine administration records
- medicines disposed of
- controlled drug record books
- medicine audits
- care plans
- training records
- medicines storage temperatures
- policies and procedures

We left ‘Have we missed you?’ cards in the home to inform residents and their representatives, who we did not meet with or were not present in the home, how to contact RQIA to tell us their experience of the quality of care provided. Flyers which gave information on raising a concern were also left in the home

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 8 May 2018

The most recent inspection of the home was an announced pre-registration inspection. There were no areas for improvement identified as a result of the inspection.

6.2 Review of areas for improvement from the last medicines management inspection

This was the first medicines management inspection to the home.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

Medicines were managed by staff who have been trained and deemed competent to do so. An induction process was in place for care staff who had been delegated medicine related tasks. The impact of training was monitored through team meetings, supervision and annual appraisal. Competency assessments were completed annually. Refresher training in medicines management was provided in the last year. A sample of training records was provided.

Systems were in place to manage the ordering of prescribed medicines to ensure adequate supplies were available and to prevent wastage. Staff advised of the procedures to identify and report any potential shortfalls in medicines. Antibiotics and newly prescribed medicines had been received into the home without delay.

There were largely satisfactory procedures in place to ensure the safe management of medicines during a resident's admission to the home and to manage changes to prescribed medicines. Personal medication records were updated by two members of staff. This safe practice was acknowledged. However, this did not always occur for handwritten entries on medication administration records. The need for this was discussed and an area for improvement was identified.

In relation to safeguarding, staff advised that they were aware of the regional procedures and who to report any safeguarding concerns to. Training had been completed.

Records of the receipt, administration and disposal of controlled drugs subject to record keeping requirements were maintained in a controlled drug record book. Checks were performed on controlled drugs which require safe custody, at the end of each shift. Additional checks were also performed on other controlled drugs which is good practice.

Community nurses were responsible for the administration of injectable medicines and recording administration on the residents' medicines records.

In relation to medicines storage, one treatment room was used to store the medicines for Cove Manor Residential Home and Cove Manor Nursing Home. Currently, the controlled drugs cabinet and the medicine refrigerator and corresponding records were also shared. Whilst it was acknowledged that the medicines were stored safely and securely and in accordance with the manufacturer's instructions, the need for separate storage/records in relation to each home was discussed. Management agreed to review this with immediate effect.

The procedures for the disposal of medicines were reviewed. We advised management that medicines do not need to be managed as clinical waste in residential care homes. It was agreed that unwanted/discontinued medicines, including controlled drugs, would be returned to the community pharmacy from the day of the inspection onwards.

Areas of good practice

There were examples of good practice in relation to staff training, competency assessment and the management of medicines on admission.

Areas for improvement

The transcribing of medicines information on the medicine administration records should involve two members of staff and both staff should sign the entry.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

The sample of medicines examined had been administered in accordance with the prescriber's instructions. There was evidence that time critical medicines had been administered at the correct time. There were arrangements in place to alert staff of when doses of weekly, monthly or three monthly medicines were due.

When a resident was prescribed a medicine for administration on a "when required" basis for the management of distressed reactions, the dosage instructions were recorded on the personal medication record. Staff knew how to recognise signs, symptoms and triggers which may cause a change in a resident's behaviour and were aware that this change may be associated with pain. The reason for and the outcome of administration were recorded. A care plan was maintained.

The sample of records examined indicated that medicines which were prescribed to manage pain had been administered as prescribed. Staff were aware that ongoing monitoring was necessary to ensure that the pain was well controlled and the resident was comfortable. Staff advised that most of the residents could verbalise any pain, and a pain assessment tool was used as needed. The reason for and the outcome of administration were recorded for analgesics prescribed on a "when required" basis. A care plan was maintained.

Staff confirmed that compliance with prescribed medicine regimes was monitored and any omissions or refusals likely to have an adverse effect on the resident's health were reported to the prescriber.

Most of the medicine records were well maintained and facilitated the audit process. There were a few spelling mistakes on the printed personal medication records and this was discussed for close monitoring.

Following discussion with the management and staff, it was evident that when applicable, other healthcare professionals were contacted in response to the residents' healthcare needs.

Areas of good practice

There were examples of good practice in relation to the standard of record keeping, care planning and the administration of medicines.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

The administration of medicines to residents was not observed during the inspection. Following discussion with staff it was evident they were knowledgeable about the residents' medicines.

Throughout the inspection, it was found that there were good relationships between the staff the residents and the residents' visitors. Staff were noted to be friendly and courteous; they treated the residents with dignity. It was clear from observation of staff, that they were familiar with the residents' likes and dislikes.

We met with two residents who expressed satisfaction with the management of their medicines the staff and their care. Comments included:

- "They are good staff and I am very happy here."
- "The food is nice; I get a choice."

- "I am doing well and I can take my medicines no problem."

One resident raised some issues in relation to their care and with the resident's consent this was discussed with management, who advised they were aware of the issues and were addressing them.

We spoke with one relative, who was complimentary regarding the staff and the care provided. She advised that she had no complaints and expressed how well her relative had improved since admission to the home.

Of the questionnaires which were left in the home to facilitate feedback from residents and their representatives, five were returned within the time frame (two weeks). The responses indicated they were very satisfied/satisfied with the care provided. One comment was made:

- "I feel the girls here are great, nothing is a problem."

Any comments in questionnaires received after the return date will be shared with the registered manager as necessary.

Areas of good practice

Staff listened to residents and relatives and took account of their views.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

We discussed arrangements in place in relation to the equality of opportunity for residents and the importance of staff being aware of equality legislation and recognising and responding to the diverse needs of residents. Arrangements were in to implement the collection of equality data.

Written policies and procedures were in place. However, these required updating to reflect the new registration regarding the residential care home and specifically, the process for the disposal of medicines. An area for improvement was identified.

There were robust arrangements in place for the management of medicine related incidents. Staff confirmed that they knew how to identify and report incidents. In relation to the regional safeguarding procedures, staff confirmed that they were aware that medicine incidents may need to be reported to the safeguarding team.

A review of the audit records indicated that largely satisfactory outcomes had been achieved. Where a discrepancy had been identified, there was evidence of the action taken.

We were advised that there were effective communication systems to ensure that all staff were kept up to date. At each shift handover, in addition to the verbal handover, a printed sheet was used to include information regarding residents' healthcare needs.

Following discussion with the staff, it was evident that they were familiar with their roles and responsibilities in relation to medicines management. They confirmed that any concerns in relation to medicines management were raised with the management team.

The staff we met with spoke positively about their work and advised there were good working relationships in the home and with other healthcare professionals. They stated they felt supported in their work and stated they had no concerns.

One online questionnaire was completed by staff with the specified time frame (two weeks). The responses were recorded as very satisfied/satisfied with the four domains of safe, effective, compassionate and well led.

Areas of good practice

There were examples of good practice in relation to governance arrangements, the management of medicine incidents and quality improvement. There were clearly defined roles and responsibilities for staff.

Areas for improvement

Policies and procedures should be further developed.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 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 Mrs Madge Quinn, Registered Manager and Mr Sean McCartney, Responsible Individual, 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.

7.1 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).

7.2 Actions to be taken by the service

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 Department of Health, Social Services and Public Safety (DHSSPS) Residential Care Homes Minimum Standards (2011)	
Area for improvement 1 **Ref**: Standard 31 **Stated:** First time **To be completed by:** 16 February 2019	The registered person shall ensure that two staff are involved in the transcribing of medicine details on medicine administration records. Ref: 6.4
	Response by registered person detailing the actions taken: All handwritten entries on medication administration is checked by 2 competent staff and signed. Handwritten entries on Kardex will be typed as soon as possible and again checked by two competent staff. This is too ensure that all medication are recorded and administered as prescribed.
Area for improvement 2 **Ref**: Standard 30 **Stated:** First time **To be completed by:** 16 February 2019	The registered person shall develop the policies and procedures regarding the residential care home and in particular the disposal of medicines. Ref: 6.7
	Response by registered person detailing the actions taken: Residential specific policies and procedures are now in place

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

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