The Regulation and Quality Improvement Authority

Inspection Report

24 March 2022

Corriewood Private Clinic

Type of service: Nursing Home
Address: 3 Station Road, Castlewellan, BT31 9NF
Telephone number: 028 4377 8230

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: Corriewood Private Clinic **Responsible Individual:** Ms Anne Monica Byrne Mrs M.I (Imelda) McGrady Mrs Maria Therese McGrady - Applicant	**Registered Manager:** Mrs Teresa Josephine McClean **Date registered:** 1 April 2005
Person in charge at the time of inspection: Ms Catherine Lenaghan, Deputy Manager	**Number of registered places:** 79 This number includes: • a maximum of 7 patients in category NH-DE to be accommodated in the Oak Tree Suite • a maximum of 23 patients in category NH-LD/LD(E) to be accommodated in the Spring Well Suite • 4 identified patients in category NH-MP accommodated in the Wild Forest Suite. The home is also approved to provide care on a day basis for 2 persons.
Categories of care: Nursing Home (NH) I – old age not falling within any other category DE – dementia MP – mental disorder excluding learning disability or dementia LD – learning disability LD(E) – learning disability – over 65 years PH – physical disability other than sensory impairment PH(E) - physical disability other than sensory impairment – over 65 years TI – terminally ill	**Number of patients accommodated in the nursing home on the day of this inspection:** 73
Brief description of the accommodation/how the service operates: Corriewood Private Clinic is a registered nursing home which provides nursing care for up to 79 persons. The home is divided into four units. Wild Forest and Annesley House provide general nursing care. Spring Well provides care for people with a learning disability. Oak Tree provides care for people with dementia. Patients have access to communal lounges, dining rooms and gardens from each unit.	

2.0 Inspection summary

An unannounced inspection took place on 24 March 2022, from 10.15am to 3.45pm. The inspection was completed by two pharmacist inspectors 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.

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.

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the quality improvement plan and include medicine related records and care plans, the management of medicines for newly admitted residents and medicines audit.

Whilst areas for improvement were identified, it was concluded that overall, with the exception of a small number of medicines, the patients were being administered their medicines as prescribed.

RQIA would like to thank the staff and patients 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. Staff views were also obtained.

4.0 What people told us about the service

To reduce footfall throughout the home, the inspector did not meet any patients. Patients were observed to be relaxing in bedrooms and communal lounges of the home.

The inspectors met with care staff, nursing staff, the deputy manager and the director of quality assurance and governance. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

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.

Feedback methods included a staff poster and paper questionnaires which were provided to the deputy manager 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 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 11 March 2022		
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 46 Criteria (2) **Stated:** Second time	The registered person shall ensure that training provided on infection prevention and control and the use of personal protective equipment is embedded into practice. **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 12 **Stated:** Second time	The registered person shall ensure that patients who require modified meals have a choice of meal at mealtimes. **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?

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.

Review of the personal medication records identified that some records were not up to date with the most recent prescription and some were incomplete. Newly prescribed antibiotic medicines had not been added to the records. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. Obsolete personal medication records had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer medicines incorrectly to the patient. An area for improvement was identified.

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.

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 nurses 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 nurses 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 the management of distressed reactions was reviewed for six patients. Directions for use were clearly recorded on the personal medication records and nurses knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. Records included the reason for and outcome of each administration. Care plans directing the use of these medicines were not in place for all patients reviewed.

The management of pain was reviewed for four patients. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. However, care plans were not in place for all patients prescribed medicines for pain relief.

Care plans which were in place lacked sufficient detail and some did not include the name of the prescribed pain relief medicine.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was too high or too low. However, the latest prescribed insulin regime was not accurately reflected in the care plan for one patient.

Care plans should be up to date and provide sufficient detail to ensure each patient's specific needs are met. An area for improvement in relation to the completion of medicine related care plans was identified.

A number of patients were prescribed medicines to be administered in the event of an epileptic seizure. Epilepsy management plans were not in place for all patients prescribed these medicines and some did not contain sufficient detail. The plans were located with the emergency medication for some but not all patients. Detailed epilepsy management plans should be in place when required. They should be readily accessible for staff. An area for improvement was identified.

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 for five patients. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

5.2.2 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 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 medicines storage areas were observed to be securely locked to prevent any unauthorised access. Trolleys used to store patients' medicines were not tidy and individual patient medicines were not always easily identifiable. The deputy manager gave an assurance that this would be addressed following the inspection and trolleys would be cleaned to maintain compliance with infection prevention and control standards.

Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the safe disposal of medicines and records were maintained.

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 the medicines administration records (MARs) were reviewed. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of the deputy manager for ongoing close monitoring. Some hand-written MARs reviewed did not state the month and year in the date section of the MAR. This is necessary to facilitate audit and review. On occasion when handwritten MARs were in use these were not checked and signed by a second member of staff to ensure that they are accurate. 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 were recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

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 plans. Written consent had been obtained and was in place when this practice occurred.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out.

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 homes internal audit process was not effective in identifying the issues raised at this inspection and needs to be expanded. An area for improvement was identified.

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 two patients recently admitted to the home from other nursing homes was reviewed. Written confirmation of the patients' medicines had not been

obtained from the GP and therefore it could not be determined if the personal medication records in place were accurate and up to date. A discrepancy was identified in the dose of a prescribed medicine which was highlighted to the deputy manager for immediate action and review. Handwritten MARs in place had not been signed and checked by a second member of staff to ensure accuracy. An area for improvement was identified.

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 the learning shared with staff in order to prevent a recurrence.

As stated in Section 5.2.3, 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.

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.

Staff in the home 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 and competency assessments.

The deputy manager advised that the finding of this inspection would be discussed with nursing staff to ensure ongoing and sustained improvement.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes, 2015.

	Regulations	Standards
Total number of Areas for Improvement	2*	6*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Daniel Oliveira, Director of Quality Assurance and Governance, and Ms Catherine Lenaghan, Deputy Manager, 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 Nursing Home Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref:** Regulation 13 (4) **Stated:** First time	The registered person shall ensure that a robust system of audit which covers all aspects of medicines management is implemented to ensure safe systems are in place. Ref: 5.2.3 & 5.2.5
To be completed by: Ongoing from the date of inspection (24 March 2022)	**Response by registered person detailing the actions taken:** The Home's Quality Assurance Framework and auditing process relating to the Safe Management of Medications was expanded and developed to ensure that any identified improvements are timely achieved.
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** First time	The registered person shall ensure that written confirmation of all new patients' medicines is obtained at or prior to admission to the home. Ref: 5.2.4
To be completed by: Immediately from the date of inspection (24 March 2022)	**Response by registered person detailing the actions taken**: The home's process for the admission of a new patient was reviewed and lessons learned were shared with the nursing team via supervision. Each new patient admission has written confirmation of all medicines as required.

Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 46 Criteria (2) **Stated:** Second time **To be completed by:** With immediate effect (11 March 2022)	The registered person shall ensure that training provided on infection prevention and control and the use of personal protective equipment is embedded into practice.
	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 12 **Stated:** Second time **To be completed by:** 11 April 2022	The registered person shall ensure that patients who require modified meals have a choice of meal at mealtimes.
	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 29 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (24 March 2022)	The registered person shall ensure that fully complete and accurate personal medication records are maintained and obsolete records are cancelled and archived. Ref: 5.2.1
	Response by registered person detailing the actions taken: A full review of the Medication Administration Record Files was completed - obsolete records were cancelled and archived. Supervisions were completed with the nursing staff. This will be monitored by management team as part of the auditing process.
Area for improvement 4 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (24 March 2022)	The registered person shall develop and update care plans regarding medicines management, in particular, distressed reactions, pain management and insulin. Ref: 5.2.1
	Response by registered person detailing the actions taken: A full review of Care Plans relating to medicines management was completed and any identified deficits acted upon. Training and supervisions were completed with the nursing staff.

Area for improvement 5 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Immediately from the date of inspection (24 March 2022)	The registered person shall ensure epilepsy management plans are in place for all patients prescribed medicines for the management of seizures. Ref: 5.2.1
	Response by registered person detailing the actions taken: A full review of patients that require an epilepsy management plan was completed. Information was triangulated between the personal epilepsy management plan and the medication care plan.
Area for improvement 6 **Ref**: Standard 29 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (24 March 2022)	The registered person shall ensure that complete records of the administration of medicines are maintained and handwritten medicine administration records are checked and signed by two members of staff. Ref: 5.2.3
	Response by registered person detailing the actions taken: A full review of the Medication Administration Record Files was completed. Supervisions were completed with the nursing staff. Ongoing oversight will be completed by management through the auditing process.

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