The Regulation and Quality Improvement Authority

Inspection Report

26 January 2023

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 Limited **Responsible Individual:** Mrs Maria Therese McGrady	**Registered Manager:** Mrs Teresa Josephine McClean **Date registered:** 1 April 2005
Person in charge at the time of inspection: Mrs Teresa Josephine McClean	**Number of registered places:** 79
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia MP – mental disorder excluding learning disability or dementia LD – learning disability LD(E) – learning disability – over 65 years 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:** 70
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 26 January 2023 from 10.30am to 3.30pm. The inspection was completed by two pharmacist inspectors and focused on the management of medicines.

At the last medicines management inspection on 24 March 2022 deficits were identified in relation to the management of medicines. Areas for improvement were identified in relation to: audit and governance, confirmation of medicines for new admissions, personal medication records, care plans, epilepsy management plans and medicine administration records.

Following the inspection, it was decided that the home would be given a period of time to implement the necessary improvements and that this follow up inspection would be carried out to ensure that the improvements had been implemented and sustained.

The outcome of this inspection provided evidence that management and staff had taken appropriate action to ensure the necessary improvements. A programme of regular medicine audits was in place to ensure patients were administered their medicines as prescribed. Written confirmation of medicines was obtained at or prior to admission for newly admitted patients. Medicine related records were maintained to a satisfactory standard. Care plans and epilepsy management plans were in place where appropriate. The management team provided assurances that they would continue to monitor all aspects of the management of medicines to ensure that these improvements were sustained.

The area for improvement identified at the last care inspection has been carried forward for review at the next care inspection.

RQIA would like to thank the management and staff for their assistance during the inspection.

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3.0 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 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. To complete the inspection the following were reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. The inspector spoke with 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 inspectors met with nurses, the deputy manager, the director of quality assurance and governance and the manager. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff were warm and friendly and it was obvious from their interactions that they knew the patients well. Staff said they had worked hard to implement and sustain improvements identified at the last inspection and had received help and support from management in order to do so.

Feedback methods included a staff poster and questionnaires which were provided to the 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 last inspection?

Areas for improvement from the last medicines inspection on 13 and 14 December 2022		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met. **See Section 5.2.1**	
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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met. **See Section 5.2.2**	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 29 **Stated:** First time	The registered person shall ensure that fully complete and accurate personal medication records are maintained and obsolete records are cancelled and archived.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met. **See Section 5.2.3**	

Area for improvement 2 **Ref:** Standard 4 **Stated:** First time	The registered person shall develop and update care plans regarding medicines management, in particular, distressed reactions, pain management and insulin.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met. **See Section 5.2.4**	
Area for improvement 3 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure epilepsy management plans are in place for all patients prescribed medicines for the management of seizures.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met. **See Section 5.2.5**	
Area for improvement 4 **Ref**: Standard 29 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement has been met. **See Section 5.2.3**	
Area for improvement 5 **Ref:** Standard 4 Criteria (9) **Stated:** First time	The registered person shall ensure that supplementary care records in relation to patients' repositioning and food intake reflect: • The position the patient has been repositioned to and from. • The actual foods consumed by the patient.	**Carried forward to the next inspection**
	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.	

5.2 Inspection findings

5.2.1 Audit and governance

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out including; running stock balances for medicines which were supplied in their original containers, a patient of the day audit, monthly themed audits and a management monthly medication audit. Action plans to address any shortcomings had been developed and implemented. Records of the audits and action plans were available for inspection. Audits completed by the inspectors indicated that the majority of medicines had been administered as prescribed. A small number of discrepancies were highlighted to the manager for investigation and close monitoring.

5.2.2 The management of medicines for new admissions

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 new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. Personal medication records and hand-written medication administration records were verified and signed by two staff to ensure accuracy.

5.2.3 Medicine records

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 majority of personal medication records were accurate and up to date with the most recent prescriptions. They had been verified and signed by two staff to ensure accuracy at the time of writing and at each update. A few minor discrepancies were highlighted to the manager for close monitoring. Obsolete personal medication records had been cancelled and archived. The standard of maintenance of the personal medication records was monitored through the home's audit process.

A sample of the medication administration records reviewed were found to have been fully and accurately completed. Hand-written records were found to be accurate however a small number had not been signed by a second member of staff to ensure accuracy. Management and staff gave an assurance that this would be done going forward and this would be monitored through the home's audit process.

5.2.4 Care plans

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, insulin etc.

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. Nurses knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain, infection or constipation. Directions for use were clearly recorded on the personal medication records. Detailed care plans directing the use of these medicines were in place. Records of administration and, the reason for and outcome of administration were maintained.

The management of pain was reviewed. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans and pain assessments were in place and reviewed regularly. Care plans for two patients required updating to detail the prescribed medicine and nurses stated that this would be actioned immediately.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail in the care plans to direct staff if the patient's blood sugar was outside their target range.

5.2.5 Epilepsy management plans

Epilepsy management plans were in place for patients prescribed medicines for the management of seizures. The care plans contained sufficient detail to direct staff in the event of a seizure. Scanned copies of the care plans were available on the electronic care system and they had recently been reviewed by the epilepsy nurse specialist. Management gave an assurance that the personal medication records for patients prescribed buccal midazolam would be updated to reflect the information in the epilepsy management plan

6.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	0	1*

*the total number of areas for improvement includes one that is carried forward for review at the next inspection.

This inspection resulted in no new areas for improvement being identified. Findings of the inspection were discussed with Mrs Teresa Josephine McClean, Registered Manager, Mr Daniel Oliveira, Director of Quality Assurance and Governance, and Ms Catherine Lenaghan, Deputy Manager, as part of the inspection process and can be found in the main body of the report.

Quality Improvement Plan

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 4 Criteria (9) **Stated:** First time **To be completed by:** 8 January 2023	The registered person shall ensure that supplementary care records in relation to patients' repositioning and food intake reflect: • The position the patient has been repositioned to and from. • The actual foods consumed by the patient.
	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

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