The Regulation and Quality Improvement Authority

Inspection Report

12 September 2023

Cornfield Care Centre

Type of service: Nursing Home
Address: Kingfisher, Nightingale and Goldfinch Suites, 51 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 Patricia Deighan **Date registered:** 10 January 2017
Person in charge at the time of inspection: Mrs Patricia Deighan	**Number of registered places:** 76 Including a maximum of 51 patients in categories NH-I, NH-PH, NH-PH(E) and a maximum of 25 patients in category NH-DE. The home is also approved to provide care on a day basis to three persons.
Categories of care: Nursing (NH): 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 DE – dementia	**Number of patients accommodated in the nursing home on the day of this inspection:** 75
Brief description of the accommodation/how the service operates: Cornfield Care Centre is a nursing home registered to provide nursing care for up to 76 patients. The home is divided into three units over one floor. One unit provides care for patients living with dementia and the other two units provide general nursing care. The home shares the same site with another registered nursing home, with the same senior management team.	

2.0 Inspection summary

An unannounced medicines management inspection took place on 12 September 2023 from 10.15am to 3.10pm. This 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.

The inspection also assessed progress with the area for improvement identified at the last medicines management inspection on 25 January 2022.

Following discussion with the aligned care inspector, it was agreed that with one exception, the areas for improvement identified at the last care inspection on 14 July 2023 would be followed up at the next care inspection. The area for improvement reviewed from the last care inspection was assessed as met.

The outcome of this inspection concluded that improvements were needed in some areas regarding the management of medicines. Two new areas for improvement were identified and one identified at the last medicines management inspection was stated for a second time. These are detailed in the quality improvement plan and include records maintained for medicines administered for distressed reactions, the management of changes to prescribed medicines and controlled drug records.

However, most medicine records and medicine related care plans were well maintained. There were auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed.

RQIA would like to thank the staff 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 inspectors 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 inspectors met with six nurses and the manager.

Staff expressed a high level of satisfaction with how the home was managed and said that they had the appropriate training to look after patients and meet their needs.

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

Feedback methods included a staff poster and paper 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, four responses had been received by RQIA from patients/relatives. These indicated that the respondents were satisfied/very satisfied with the care provided. One commented that "the staff are very friendly and welcoming, xx needs are met and we are kept fully informed".

5.0 The inspection

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

Area for improvement from the last medicines management inspection on 25 January 2022		
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 18 **Stated:** First time	The registered person shall ensure that the reason for and the outcome of administration is recorded on every occasion, when medication is administered on a 'when required' basis, for the management of distressed reactions.	**Not met**
	Action taken as confirmed during the inspection: Although the manager advised that this was the expected practice, this was not recorded consistently on records examined for all medicines prescribed for use 'when required' for the management of distressed reactions. **This area for improvement was stated for a second time.**	

Areas for improvement from the last care inspection on 14 July 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 21 (1) (a) (b) **Stated:** First time	The registered person shall ensure that Access NI checks are completed prior to any staff commencing work in the home.	**Carried forward to the next inspection**
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Area for Improvement 2 **Ref:** Regulation 14 (2) (a) **Stated:** First time	The registered persons shall ensure that all areas of the home to which patients have access are free from hazards to their safety.	**Carried forward to the next inspection**
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Area for Improvement 3 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that the IPC issues identified during inspection are addressed.	**Carried forward to the next inspection**
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that where a patient requires pressure area care, a care plan is in place detailing the recommended frequency of repositioning; and that this is accurately reflected and recorded in the corresponding repositioning chart.	**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.	

Area for improvement 2 **Ref:** Standard 4 **Stated:** First time	The registered person shall ensure that care plans provide sufficient details that are reflective of the patient's current needs and any relevant medical conditions.	**Carried forward to the next inspection**
	A number of medicine related care plans were examined and although most of these were found to be appropriate, a small number of additions/amendments were agreed and nurses/the manager stated these would be addressed following the inspection. **However, action required to ensure compliance with this standard was not fully reviewed as part of this inspection and this is carried forward to the next inspection.**	
Area for improvement 3 **Ref:** Standard 30 **Stated:** First time	The registered person shall ensure that prescribed topical creams and supplements are stored safely and securely as per the manufacturers' instructions and safely disposed as required.	**Met**
	Action taken as confirmed during the inspection: Creams and supplements were observed to be stored safely and securely. This was observed during a walk around the units and confirmed during discussion with nurses on each unit.	

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 medical 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 mostly 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. A couple of minor discrepancies were highlighted and addressed immediately.

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.

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 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 distressed reactions was reviewed. Directions for use were recorded on personal medication records; and care plans directing the use of these medicines were in place. Nurses knew how to recognise a change in a patient's behaviour and were aware of the factors that this change may be associated with. Records did not always include the reason for and outcome of administration. An area for improvement identified at the last medicines management inspection was stated for a second time (see Section 5.1).

The management of pain was discussed. 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. One care plan was not up to date with the most recent changes to pain medicines for the patient although medicines were being administered as prescribed. It was agreed that this would be addressed following the inspection (see Section 5.1).

A care plan was not in place for the use of adrenaline in potential anaphylaxis. It was agreed that this would be addressed following the inspection, to include relevant details including the location of the emergency medication (see Section 5.1).

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.

The management of thickening agents and food supplements was reviewed. A speech and language assessment report and care plan was in place. Records of prescribing and administration, which included the recommended consistency level as appropriate, were maintained.

Care plans were in place when patients required insulin to manage their diabetes.

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.

When changes are made to prescribed medicines, records must be updated promptly and discontinued medicines removed to reduce the risk of administration. Two examples were observed whereby medicine changes were unclear on personal medication records and/or communicated via an attached note. In addition, nurses were removing and discarding discontinued/on hold medicines from the monitored dosage system in which the medicines were supplied, at the time of each daily administration. Changes should be made and recorded promptly and appropriately following receipt of information about medicine changes. An area for improvement was identified.

The records inspected showed that the majority of medicines were available for administration when patients required them. It was agreed that two medicines with stock supply issues would be referred to the prescriber for review.

The medicines storage areas were observed to be locked to prevent any unauthorised access when not in use. They were clean, tidy and organised so that medicines belonging to each patient could be easily located. The temperature of medicines storage areas was monitored and recorded. Medicine refrigerators and controlled drugs cabinets were available for use as needed.

Satisfactory arrangements were in place for the safe 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 the medicines administration records was reviewed and these were found to have been accurately completed. A small number of minor discrepancies were brought to the attention of nurses and immediately addressed. The records were filed once completed.

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 the controlled drug record book. There were mostly satisfactory arrangements in place for the management of controlled drugs. However, balances for controlled drugs in one unit had been adjusted and entries completed in advance for administration due to take place in the evening, rendering stock balances inaccurate. Although it was acknowledged that these medicines had been administered as prescribed, records must be completed contemporaneously by the two staff involved, in line with legislative requirements, professional standards and guidelines. An area for improvement was identified.
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. Consent was recorded and care plans were in place when this practice occurred.

Management and staff audited medicines administration within the home. A range of audits were carried out. The date of opening was recorded on the majority of medicines so that they could be easily audited which is good practice.

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 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. 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 nurses 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.

The audits completed at the inspection indicated that medicines were being administered as prescribed. A review of management audits indicated that the issues raised had not been

identified. It was agreed that the areas for improvement and those highlighted for discussion in this report, would be included in audit procedures.

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

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	3*	5*

* The total number of areas for improvement includes one that has been stated for a second time and five which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Patricia Deighan, Registered 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 21 (1) (a) (b) **Stated:** First time **To be completed by:** From the date of the inspection (14 July 2023)	The registered person shall ensure that Access NI checks are completed prior to any staff commencing work in the home. **Action required to ensure compliance with this regulation 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:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** From the date of the inspection (14 July 2023)	The registered persons shall ensure that all areas of the home to which patients have access are free from hazards to their safety. **Action required to ensure compliance with this regulation 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**: Regulation 13 (7) **Stated:** First time **To be completed by:** From the date of the inspection (14 July 2023)	The registered person shall ensure that the IPC issues identified during inspection are addressed. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref:** Standard 18 **Stated:** Second time **To be completed by:** With immediate effect (12 September 2023)	The registered person shall ensure that the reason for and the outcome of administration is recorded on every occasion, when medication is administered on a 'when required' basis, for the management of distressed reactions. Ref: 5.1 & 5.2.1 **Response by registered person detailing the actions taken:**

	The administration medicine records have been reviewed and updated in regard to prescriptions for patients who require medicines as and when required for distressed reactions. Registered nurses have been made aware through staff meetings and supervisions that patient's care records must be updated accurately and appropriately on each occasion in this regard.
Area for improvement 2 **Ref**: Standard 23 **Stated:** First time **To be completed by:** 28 July 2023	The registered person shall ensure that where a patient requires pressure area care, a care plan is in place detailing the recommended frequency of repositioning; and that this is accurately reflected and recorded in the corresponding repositioning chart.
	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 4 **Stated:** First time **To be completed by:** 28 July 2023	The registered person shall ensure that care plans provide sufficient details that are reflective of the patient's current needs and any relevant medical conditions.
	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 4 **Ref:** Standard 28 **Stated:** First time **To be completed by:** With immediate effect (12 September 2023)	The registered person shall ensure that changes made to prescribed medicines are recorded clearly on personal medication records and any discontinued medicines removed from stock promptly to prevent their potential administration in error. Ref: 5.2.2
	Response by registered person detailing the actions taken: Changes made to prescribed medicines are recorded clearly on personal medication records and signed by 2 nurses. Monitored dosage system is returned to pharmacy promptly along with personal medication record. Discontinued medicines are removed by Pharmacist and updated Monitored dosage system returned.

Area for improvement 5 **Ref:** Standard 31 **Stated:** First time **To be completed by:** With immediate effect (12 September 2023)	The registered person shall ensure that controlled drug records are completed contemporaneously by the two members of staff involved, in line with legislative requirements, professional standards and guidelines. Ref: 5.2.3
	Response by registered person detailing the actions taken: All controlled drug records are completed contemporaneously by the two members of staff involved in administering medication to the patient, in line with legislative requirements, professional standards and guidelines.

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