Inspection Report
9 March 2021

The Cottage

Type of Home: Nursing Home
Address: 25 Lodge Park, Coleraine BT52 1UN
Tel No: 028 7034 4280
Inspector: Helen Daly

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 nursing home which is registered to provide nursing care for up to 67 patients with a range of care needs as detailed in Section 2.0.

2.0 Service details

Organisation/Registered Provider: Merit Retail Limited **Responsible Individual:** Ms Therese Elizabeth Conway	**Registered Manager and date registered:** Mrs Carol McAlary 8 November 2017
Person in charge at the time of inspection: Mrs Carol McAlary	**Number of registered places:** 67 This number includes: • a maximum of 14 patients in category NH-DE to be accommodated in the designated dementia unit, and • a maximum of three patients in category NH-TI The veranda on the first floor must not be accessed by any patients until the agreed remedial work has been completed.
Categories of care: Nursing Home (NH) I – old age not falling within any other category DE – dementia PH – physical disability other than sensory impairment PH (E) - physical disability other than sensory impairment – over 65 years TI – terminally ill	**Total number of patients in the nursing home on the day of this inspection:** 58

3.0 Inspection focus

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

The home was requested to submit a range of documents and completed records in relation to medicines management. These were received by RQIA on 23 February 2021 and reviewed by the pharmacist inspector. This information included the completion of a self-assessment specific to medicines management in the home. Feedback was discussed with the manager during the remote inspection on 9 March 2021.

This inspection focused on medicines management within the home. Following discussion with the care inspector it was agreed that the areas for improvement in relation to care identified at the last care inspection (7 September 2020) would not be reviewed at this inspection. They will be assessed at the next care inspection in the home.

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.

As part of the inspection process we:

- spoke to patient representatives via telephone
- spoke to management about how they plan, deliver and monitor the care and support provided in the home
- reviewed the submitted documents to confirm that appropriate records were kept

The following areas regarding medicines management were examined and/or discussed:

- personal medication records
- medicine administration records
- disposal of medicines
- care plans related to medicines management
- governance and audit
- controlled drugs
- staff training and competency
- medicine storage temperatures
- completed medicines management self assessment

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	1*	2*

*The total number of areas for improvement includes three that have been carried forward for review at the next care inspection and are detailed in the Quality Improvement Plan (QIP).

No new areas for improvement were identified at this inspection. The findings were discussed with Mrs Carol McClary, Register Manager, and one senior nurse, as part of the inspection process.

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 inspection (7 September 2020)?

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 27 **Stated:** First time	The registered person shall ensure that a refurbishment plan is implemented in relation to the environment to include the repair or replacement of identified furniture, the refurbishment of the kitchenette within the Benone Suite, floors within identified rooms and walls in multiple areas throughout the home. **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 care inspection.**	**Carried forward forward to the next care inspection**
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 44.3 **Stated:** First time	The registered person shall ensure that the nursing home, including all spaces, is only used for the purpose for which it is registered. With specific reference to ensuring that the equipment stored in the identified bathroom within the Rose Suite is removed.	**Carried forward to the next care inspection**

	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 care inspection.	
Area for improvement 2 **Ref**: Standard 46.2 **Stated:** First time	The registered person shall ensure robust cleaning schedules are implemented for patient equipment with particular reference to patient wheelchairs.	**Carried forward to the next care inspection**
	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 care inspection.	

6.0 What people told us about this home?

We asked the manager to provide contact details for patients/patient's representatives who gave consent to be contacted by the inspector. We spoke with four patients' relatives/representatives. They said that they were "satisfied/very satisfied" with the care provided to the patients.

Comments made were largely positive and included:

- "They are really good to my xxx (relative). I visit her every week and she says that everything is great. I can't complain about the place."
- "I am very happy with the care. The staff are fantastic. The staff are caring and look after my xxx well. I am a care partner, the staff have been helpful with that."
- "The communication is excellent. The care and staff are great. The staff know my xxx very well. They provide individualised care. Xxx would not be easy to care for but they do."

We spoke with the registered manager and one of the nursing sisters.

Other feedback methods included posters which were provided to the registered manager to display so that staff and/or patients could complete a questionnaire. At the time of issuing this report, no responses had been received.

7.0 Inspection Findings

7.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients 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 patients' needs will change and

therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a 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. These are records used to list all 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 e.g. at medication reviews, hospital appointments.

The personal medication records reviewed were accurate and up to date. In line with best practice, a second nurse had checked and signed the personal medication records when they were written and updated to check that they were accurate.

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, self-administration 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 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.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions for two patients. 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. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were available in the medicines file. Records of administration were clearly recorded. The reason for and outcome of administration were recorded. The manager advised that any regular use would be referred to the prescriber for review.

The management of pain was reviewed for two patients. Care plans were in place and the records of prescribing and administration indicated that medicines were administered as prescribed.

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.

We reviewed the management of thickening agents for two patients. Up to date speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level 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 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. The manager advised that an effective stock ordering system was in place and that any potential out of stocks were followed up without delay.

We discussed the disposal arrangements for medicines. The manager told us that discontinued medicines were collected by a waste management company and that controlled drugs were denatured prior to disposal.

Medicines storage was discussed. The manager advised that the treatment rooms were securely locked to prevent any unauthorised access and that medicines belonging to each patient could be easily located. In relation to the cold storage of medicines, daily medicine refrigerator temperatures were monitored and records showed the the temperatures were within the recommended limits.

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 patients to ensure that they are receiving the correct prescribed treatment.

A sample of personal medication records and medication administration records were submitted for review. These records were found to have been fully and accurately completed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The manager told us that the receipt, administration and disposal of controlled drugs were recorded in controlled drug record books and that stock balances were checked at each handover of responsibility.

The manager had submitted a range of audits which indicated that medicines had been administered as prescribed. Action plans to address any shortfalls in the management of medicines had been implemented and addressed.

A small number of patients have their medicines administered covertly. The manager advised that this had been agreed by family, the prescriber, care manager and herself and that care plans were in place. It was agreed that the care plans would be updated to include details of how the medicines were to be administered to ensure that all nurses were adhering to safe practice

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 two patients who had been admitted to the home. Written confirmation of their current medication regimes had been received. The personal medication records had been verified and signed by two nurses. Medicines had been accurately received into the home and administered in accordance with the most recent directions. One anomaly was identified and this was discussed with the manager for follow up.

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.

The audit system in place helps staff to identify medicine related incidents. Management and staff were familiar with the type of incidents that should be reported.

We discussed the medicine related incident which had been reported to RQIA since the last inspection. There was evidence that the incident had been reported to the prescriber for guidance, investigated and learning shared with staff in order to prevent a recurrence.

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 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 staff are competent in managing medicines and that staff are supported.

The information provided indicated that staff responsible for managing medicines had received training and been deemed competent and that there were arrangements in place to provide annual refresher training. The most recent training was in relation to the management of thickening agents.

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 medicines were managed safely in the home and patients were being administered their medicines as prescribed by their GP. No areas for improvement in relation to medicines management were identified.

Feedback from patients' families was positive.

We would like to thank the management and staff for their assistance prior to and throughout the inspection. We would also like to thank the relatives who provided feedback on the care provided in the home.

9.0 Quality Improvement Plan

There were no new areas for improvement identified during this medicines management inspection. The QIP states areas for improvement which have been carried forward for review at the next inspection.

Quality Improvement Plan	
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 27 **Stated:** First time	The registered person shall ensure that a refurbishment plan is implemented in relation to the environment to include the repair or replacement of identified furniture, the refurbishment of the kitchenette within the Benone Suite, floors within identified rooms and walls in multiple areas throughout the home.
To be completed by 31 May 2020	**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 care inspection.** Ref: 5.0
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 44.3 **Stated:** First time	The registered person shall ensure that the nursing home, including all spaces, is only used for the purpose for which it is registered. With specific reference to ensuring that the equipment stored in the identified bathroom within the Rose Suite is removed.
To be completed by: 14 March 2020	**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 care inspection.** Ref: 5.0

Area for improvement 2 **Ref**: Standard 46.2 **Stated:** First time **To be completed by:** 31 October 2020	The registered person shall ensure robust cleaning schedules are implemented for patient equipment with particular reference to patient wheelchairs. **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 care inspection.** Ref: 5.0

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