Inspection Report

23 November 2021

Cove Manor

Type of service: Nursing Home
Address: 89 Mullanahoe Road, Ardboe, Dungannon, BT71 5AU
Telephone number: 028 8673 6424

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: Cove Manor Care Home Ltd **Registered Person:** Mr Sean McCartney	**Registered Manager:** Mrs Noreen Monaghan **Date registered:** 19 August 2021
Person in charge at the time of inspection: Mrs Noreen Monaghan	**Number of registered places:** 17 This number includes category NH-DE for three identified patients only and category NH-MP for one identified patient only. The home is also approved to provide care on a day basis only for three persons.
Categories of care: Nursing Home (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	**Number of patients accommodated in the nursing home on the day of this inspection:** 16
Brief description of the accommodation/how the service operates: This a nursing home registered to provide nursing care for up to 17 patients. The home is located in the same building as a registered residential care home. The registered manager has responsibility for the managerial oversight of both services.	

2.0 Inspection summary

An unannounced inspection took place on 23 November 2021, from 10.40am to 3.00pm. The inspection was undertaken by a pharmacist inspector and focused on medicines management within the home.

Following discussion with the aligned care inspector, it was agreed that one of the areas for improvement identified at the last care inspection would be followed up at the next care inspection.

Review of medicines management found that patients were being administered their medicines as prescribed. Arrangements were in place to ensure that staff received training and were deemed competent in medicines management. Most of medicine records were well maintained and medicines were stored safely and securely. Systems were in place to audit medicines management on a regular basis. Two new areas for improvement were identified regarding the accurate maintenance of personal medication records and medication administration records.

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, reported 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 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

Patients were observed to be relaxed and content in the home. The inspector met with the manager and one of the owners who is also a senior care assistant. Staff were observed to be warm and friendly and it was evident from discussions that they knew the patients well.

All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff stated that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

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, no responses 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 27 July 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 21(1)(b) Schedule 2(3) **Stated:** First time	The registered person shall ensure that all persons are recruited in accordance with best practice and legislation and that the efficacy of this is present in staff recruitment and selection files prior to commencing employment. This refers specifically to obtaining a reference from the present or most recent employer.	**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 summary**
Area for improvement 1 **Ref:** Standard 16(11) **Stated:** First time	The registered person shall ensure that a format of recording complaints is put in place which includes whether or not the complainant was satisfied with the outcome of any actions taken.	**Met**
	Action taken as confirmed during the inspection: The format of recording complaints had been revised to include whether or not the complainant was satisfied with the outcome of any actions taken.	

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 will 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 community pharmacists.

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 and hospital appointments.

The personal medication records reviewed at the inspection were mostly accurate and up to date. In line with best practice, a second nurse had verified and signed the personal medication records when they were written and updated. However, a small number of discrepancies were observed when compared to medication administration records (MARs) and prescriptions. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. These records must match and reflect the prescriber's most recent instructions. An area for improvement was identified.

It was agreed that records no longer in use would be marked as discontinued and archived promptly.

Copies of patients' prescriptions/hospital discharge letters were retained in the home. Staff were reminded to use these to cross check entries on personal medication records.

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 for four patients. The nurse on duty 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 recorded on personal medication records and care plans directing the use of these medicines were in place.

Records of administration were maintained. The reason for and outcome of administration were recorded on the majority of occasions. This should be recorded on all occasions and it was agreed this would be addressed.

The management of pain was discussed. The manager advised that staff were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans were in place.

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. They were tidy and organised so that medicines belonging to each patient could be easily located. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Appropriate arrangements were in place for the 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.

Within the home, a record of the administration of medicines is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. Most of the records were found to have been fully and accurately completed (see also Section 5.2.1). Records were filed once completed. When MARs or individual entries had been handwritten they had not been verified and signed by two nurses to ensure accuracy. 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 appropriately in a controlled drug record book.

Management and staff audited the management and administration of medicines on a regular basis. The date of opening was recorded on medicines so that they could be easily audited. Where shortfalls had been identified action plans were developed and implemented. It was agreed that the areas for improvement identified at this inspection would be included in audit procedures.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

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 recently admitted patients or patients returning to the home following discharge from hospital was reviewed. There was evidence that robust arrangements were in place to ensure that written confirmation of the patients' current medicine regime was obtained and the GP and community pharmacy were contacted as necessary. Personal medication records had been accurately written. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

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.

There had been no medicine related incidents reported to RQIA since the last medicines management inspection. The audit system in place helps staff to identify most medicine related incidents. Management and staff were familiar with the type of incidents that should be reported. As discussed, it was agreed that the audit system should include the areas for improvement identified so that 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 staff are competent in managing medicines and that staff are supported. Policies and procedures should be up to date and readily available for staff.

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.

Records of staff training in relation to medicines management were available for inspection.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led regarding the management of medicines.

Although two new areas for improvement were identified in relation to the maintenance of medicine records, the patients were being administered their medicines as prescribed.

We would like to thank the patients and staff for their assistance throughout the inspection.

7.0 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/or the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	*2	1

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Noreen Monaghan, Registered Manager, and Mrs Kate McVey, Home Owner, 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)(b) Schedule 2(3) **Stated:** First time **To be completed by:** 28 July 2021	The registered person shall ensure that all persons are recruited in accordance with best practice and legislation and that the efficacy of this is present in staff recruitment and selection files prior to commencing employment. This refers specifically to obtaining a reference from the present or most recent employer.
	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 13(4) **Stated:** First time **To be completed by:** 23 December 2021	The registered person shall ensure that personal medication records and medication administration records match and accurately reflect the prescriber's most recent instructions. Ref: 5.2.1
	Response by registered person detailing the actions taken: The registered person shall ensure that the prescribers most recent instructions are reflected.
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 29 **Stated:** First time **To be completed by:** Immediate and ongoing	The registered person shall ensure that two nurses verify and sign handwritten entries on medication administration records. Ref: 5.2.3
	Response by registered person detailing the actions taken: The registered person shall ensure that this is in place.

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

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