

Inspection Report

20 June 2024



Cove Manor

Type of service: Nursing Home
Address: 89 Mullanhoe Road, Ardboe,
Dungannon, BT71 5AU
Telephone number: 028 8673 6349

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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

<p>Organisation/Registered Provider: Cove LeaseCo Limited</p> <p>Registered Person: Mr Conor O'Brien</p>	<p>Registered Manager: Mrs Charmaine Ferguson, not registered</p>
<p>Person in charge at the time of inspection: Mrs Charmaine Ferguson</p>	<p>Number of registered places: 17</p> <p>Including: 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 to three persons.</p>
<p>Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment MP – mental disorder excluding learning disability or dementia</p>	<p>Number of patients accommodated in the nursing home on the day of this inspection: 17</p>
<p>Brief description of the accommodation/how the service operates: Cove Manor is a nursing home registered to provide nursing care for up to 17 patients.</p> <p>There is a residential care home which occupies the same building with shared communal areas and dining room. The manager for this home manages both services.</p>	

2.0 Inspection summary

An unannounced inspection took place on 20 June 2024, from 10.20am to 3.35pm. This was completed by a pharmacist inspector and focused the management of medicines 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.

Two areas for improvement identified at the last medicines management inspection were reviewed. The two areas for improvement identified at the last care inspection will 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. One area for improvement was stated for a second time and two new areas for improvement were identified. Areas for improvement are detailed in the Quality Improvement Plan (QIP) and include the accurate maintenance of personal medication records, the cancellation/archiving of obsolete medicine records and the maintenance of records regarding the administration of medicines, prescribed for use 'when required,' for the management of distressed reactions.

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. Discussions were held about how staff and management plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

The inspector met with the manager and briefly with some of the care staff and patients. The manager said that she was receiving the appropriate training and support to manage the home and to look after patients and meet their needs.

Staff interactions 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, no responses had been received.

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 31 May 2024		
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 personal medication records and medication administration records match and accurately reflect the prescriber's most recent instructions.	Partially met
	Action taken as confirmed during the inspection: This area for improvement was assessed as partially met and is stated for a second time. See section 5.2.1.	
Area for improvement 2 Ref: Regulation 13 (8) (a) Stated: First time	The registered person shall make good the locking mechanism in all bathroom / toilet doors to ensure the privacy of patients is maintained at all times.	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, December 2022		Validation of compliance
Area for improvement 1 Ref: Standard 29 Stated: First time	The registered person shall ensure that two nurses verify and sign handwritten entries on medication administration records.	Met
	Action taken as confirmed during the inspection: Handwritten entries on medication administration records had been verified and signed by two trained members of staff. This area for improvement was assessed as met.	

Area for improvement 2 Ref: Standard 38(3) Stated: First time	The registered person shall put in place a recruitment checklist for all new employees so as to ensure managerial oversight in the safe recruitment of staff.	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 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.

The majority of entries on personal medication records reviewed were 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. However, a number of discrepancies were observed, which could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. These were discussed in detail with the manager and an area for improvement was stated for a second time.

Obsolete personal medication records had not been promptly cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error. This had been highlighted for attention at the last medicines management inspection. 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 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. Directions for use were recorded on personal medication records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. However, records did not always include the reason for and outcome of each administration. This had been highlighted for attention at the last medicines management inspection. An area for improvement was identified.

The management of pain was discussed. Staff 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.

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 food supplements was reviewed. A speech and language assessment report and care plan was in place. Personal medication records included the prescribed consistency. One care plan detailed the wrong consistency level, this was addressed immediately; the patient had received the correct consistency. The manager was reminded to include the prescribed consistency level on medication administration records.

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.

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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. It was agreed that if the medicines trolley continues to be stored in the dining room, then the temperature of this area would be monitored and recorded on a daily basis. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the safe disposal of medicines. The layout of the record was reviewed with the manager and it was agreed that the format would be amended so that the name of the patient and the signatures of the two staff involved could be recorded easily on every occasion.

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. Most of the records were found to have been accurately completed. A couple of missed signatures were brought to the attention of the manager for monitoring. The audits completed at the inspection indicated that the medicines had been administered as prescribed. The records were filed once completed and were readily available for audit and review.

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 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 and care plans were 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 date of opening was recorded on medicines so that they could be easily audited. This 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 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.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed. A couple of small discrepancies in inhaled medicines were observed and discussed. The manager agreed to ensure these were monitored within 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. Medicines management policies and procedures were in place.

It was agreed that the findings of this inspection would be shared with staff for ongoing 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, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	2*	3*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Charmaine Ferguson, 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: Second time To be completed by: From the date of the inspection onwards (20 June 2024)	The registered person shall ensure that personal medication records and medication administration records match and accurately reflect the prescriber's most recent instructions. Ref: 5.1 & 5.2.1
	Response by registered person detailing the actions taken: This point has been discussed with all nursing staff and is monitored monthly by theHM.
Area for improvement 2 Ref: Regulation 13 (8)(a) Stated: First time To be completed by: 3 June 2024	The registered person shall make good the locking mechanism in all bathroom / toilet doors to ensure the privacy of patients is maintained at all times. 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, December 2022	
Area for improvement 1 Ref: Standard 38 (3) Stated: First time To be completed by: 28 June 2024	The registered person shall put in place a recruitment checklist for all new employees so as to ensure managerial oversight in the safe recruitment of staff. 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

<p>Area for improvement 2</p> <p>Ref: Standard 18</p> <p>Stated: First time</p> <p>To be completed by: From the date of the inspection onwards (20 June 2024)</p>	<p>The registered person shall ensure that accurate records are maintained of the reason for and outcome of the administration of medicines, prescribed on a 'when required' basis for the management of distressed reactions.</p> <p>Ref: 5.2.1</p>
<p>Area for improvement 3</p> <p>Ref: Standard 29</p> <p>Stated: First time</p> <p>To be completed by: From the date of the inspection onwards (20 June 2024)</p>	<p>Response by registered person detailing the actions taken: A new distressed template is in use as required for each resident which recrds the reason for and outcome of the administration of medicines.</p> <hr/> <p>The registered person shall ensure that obsolete personal medication records are promptly cancelled and archived.</p> <p>Ref: 5.2.1</p> <p>Response by registered person detailing the actions taken: Obsolete personal medication recirds were removed on day of visit and continue to be monitored by the nursing staff and HM.</p>

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The **Regulation** and
Quality Improvement
Authority

The Regulation and Quality Improvement Authority
James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
 [@RQIANews](https://twitter.com/RQIANews)

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