The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Cove Manor**

Provider: **Cove LeaseCo Limited**

Date of Inspection: **21 and 24 April 2026**

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 LeaseCo Limited
Responsible Individual:	Mr Conor O'Brien
Registered Manager:	Miss Charmaine Ferguson

Service Profile:

This home is a registered residential care home, which provides health and social care for up to 14 residents within the category of frail elderly over 65 years of age, physical disability over and under 65 years of age and mental health over 65 years of age for two residents.

The home is over two floors providing communal living areas and a communal dining room. Communal areas are shared with the registered nursing care home, which occupies the same building and the registered manager for this home manages both services.

2.0 Inspection summary

An unannounced inspection took place on 21 April 2026, between 9:20am and 1:40pm by a care inspector and 24 April 2026 between 10:05am and 1:15pm by a pharmacy inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 5 August 2025, and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

It was evident that staff promoted the dignity and well-being of residents. Residents said that living in the home was a good experience. Residents unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

Review of medicines management found that satisfactory arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and residents were administered their medicines as prescribed.

As a result of this inspection, it was positive to note that six areas for improvement were assessed as having been addressed by the provider. One area for improvement has been stated for a second time. Full details, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 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 against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from residents, relatives, staff or the commissioning Trust.

Throughout the inspection process, inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Residents spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Residents' comments included: "The staff are lovely here", "I have no concerns at all", "This is a great place", "Everyone (staff) is very friendly here" and "I feel safe here".

Staff said that the management team were very approachable, teamwork was great and that they felt well supported in their role. Comments included: "This is a great home and I really enjoy working here", "Staffing levels are good" and "We are a very good team here".

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of residents. There was evidence of robust systems in place to manage staffing.

Observation of the delivery of care evidenced that residents' needs were met by the number and skills of the staff on duty.

Residents said that there was enough staff on duty to help them. Staff said there was good teamwork and that they felt well supported in their role and that they were satisfied with the staffing levels.

It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

3.3.2 Quality of Life and Care Delivery

Staff interactions with residents were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed and pleasant. Staff were knowledgeable of individual residents' needs, their daily routine, wishes and preferences.

It was observed that staff respected residents' privacy by their actions, such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly. Staff were also observed offering residents choice in how and where they spent their day or how they wanted to engage socially with others.

At times, some residents may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. It was established that safe systems were in place to safeguard residents and to manage this aspect of care.

Where a resident was at risk of falling, measures to reduce this risk were put in place. For example, mobility aids and assistance from staff. Referrals were made to other healthcare professionals as needed.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff and their diet modified. A menu was on display offering a choice of two meals.

The dining experience was an opportunity for residents to socialise, and the atmosphere was calm, relaxed and unhurried. It was observed that residents were enjoying their meal and their dining experience. A mealtime co-ordinator was allocated to oversee the correct delivery of meals to residents.

Residents commented positively about the food provided within the home with comments such as: “The food is lovely and we get a good choice”, “If I don’t like something they (staff) make me something different” and “The food is always nice”.

The importance of engaging with residents was well understood by the manager and staff. A schedule of activities was on display within the home offering a range of activities such as; baking, artwork, board games and chair aerobics.

Care assistants completed the activities and were observed positively engaging with residents and encouraging them to participate. Board games were provided in the morning; artwork and a tea party was provided in the afternoon. Residents appeared to enjoy the activities provided.

Residents commented positively regarding the activities provided within the home and were seen to be content and settled in their surroundings and in their interactions with staff. Comments included: “There is always something to do here, we are never bored”, “I really enjoy the activities” and, “(The) staff are very good”.

Some residents were engaged in their own activities such as; watching TV, resting or chatting to staff and arrangements were in place to meet residents’ social, religious and spiritual needs within the home.

3.3.3 Management of Care Records

Residents’ needs were assessed by a suitably qualified member of staff at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents’ needs and included any advice or recommendations made by other healthcare professionals. Residents’ care records were held confidentially.

Care records were person centred and regularly reviewed to ensure they continued to meet the residents’ needs. Staff recorded regular evaluations about the delivery of care.

3.3.4 Quality and Management of Residents’ Environment Control

The home was fresh smelling, neat and tidy and residents’ bedrooms were found to be personalised with items of memorabilia and special interests. Bedrooms and communal areas were clean, tidy and comfortable.

Whilst most areas of the home were suitably furnished, warm and comfortable, a number of walls required painting and surface damage was evident to identified floor coverings, bedroom furniture, doors and architraves. Details were discussed with the management team who advised that painting was ongoing throughout the home and that an improvement plan had already been implemented to address the environmental issues. Progress with this will be reviewed at a future inspection.

A number of other environmental shortfalls were identified requiring either repair and/or replacement; details were discussed with the management team who agreed to have these reviewed. Following the inspection, written confirmation was received that relevant action had been taken to address these findings.

Three fire doors were not closing properly. Details were discussed with the management team and an area for improvement has been stated for a second time.

A Fire Risk Assessment (FRA) had been completed on the 10 April 2026; the manager confirmed the action taken to address any recommendations that were made by the fire risk assessor.

Review of a number of windows identified that they were not fitted with tamper proof restrictors and some windows were opening wider than recommended. This was discussed with the manager who agreed to have all windows reviewed. Following the inspection, written confirmation was received that relevant action had been taken to address this.

Personal protective equipment (PPE) and hand sanitising gel was available within the home. There was evidence that systems and processes were in place to manage infection prevention and control (IPC). One staff member was wearing nail polish that would inhibit effective hand hygiene. Details were discussed with the manager and the necessary action was taken to address this.

3.3.5 Medicines Management

Monitoring and review of medicines management

Residents in residential care homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times residents' needs may 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.

Residents in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each resident. 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 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 confirm that they were accurate.

Copies of residents' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription.

All residents 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.

The management of distressed reactions, pain, clozapine, lithium and thickening agents was reviewed. Care plans contained sufficient detail to direct the required care. Medicine records

were well maintained. The audits completed indicated that medicines were administered as prescribed.

Supply storage and disposal

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the resident'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 medicine storage area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each resident could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage, the safe disposal of medicines and the storage of controlled drugs.

Medicines administration

It is important to have a clear record of which medicines have been administered to residents to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. The records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Controlled drugs are medicines, which are subject to strict legal controls and legislation. They commonly include strong painkillers. 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.

Management and staff audited the management and administration of medicines on a regular basis within the home. There was evidence that the findings of the audits had been discussed with staff and addressed. The date of opening was recorded on medicines to facilitate audit and disposal at expiry.

Transfer of medicines

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 at the time of admission or for residents returning from hospital. Written confirmation of prescribed medicines was obtained at or prior to admission and details shared with the GP and community pharmacy. Medicine records had been accurately completed and there was evidence that medicines were administered as prescribed.

Management of medicine 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 medicines were being administered as prescribed.

Medicines management training

To ensure that residents are well looked after and receive their medicines appropriately, staff who administer medicines to residents must be appropriately trained. The registered person has a responsibility to check that 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. Medicines management policies and procedures were in place.

It was agreed that the findings of this inspection would be discussed with staff to facilitate ongoing improvement.

3.3.6 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Miss Charmaine Ferguson has been the Manager in this home since 15 May 2025.

Residents and staff commented positively about the manager and described her as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

4.0 Quality Improvement Plan/Areas for Improvement

An area for improvement has been identified where action is required to ensure compliance with Regulations.

	Regulations	Standards
Total number of Areas for Improvement	1*	0

* The total number of areas for improvement includes one regulation that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with the management team, 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 27 (4) (b) **Stated:** Second time **To be completed by:** 21 April 2026	The registered person shall review all fire doors in the home, and ensure they all function as required. Ref: 3.3.4
	Response by registered person detailing the actions taken: All doors fixed/adjusted and now closing.

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

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