Unannounced Care Inspection Report
18 October 2016

Cove Manor

Type of Service: Nursing Home
Address: 89 Mullanahoe Road, Ardboe, Dungannon, BT71 5AU
Tel no: 028 8673 6349
Inspector: Dermot Walsh

1.0 Summary

An unannounced inspection of Cove Manor took place on 18 October 2016 from 09.40 to 17.10 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

Relevant checks were conducted within the recruitment process prior to a staff member commencing in post. RQIA were suitably informed of notifications under Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. A safe system for monitoring compliance with mandatory training was in place. Compliance with best practice in infection prevention and control was well maintained. Two requirements were made regarding monitoring the registration status of current nursing and care staff and post falls management. One recommendation was made in this domain regarding environmental issues identified on inspection.

Is care effective?

Staff were aware of the local arrangements for referral to health professionals. Patients and staff demonstrated confidence and awareness in raising any potential concerns to the relevant people. Staff meetings were held regularly. One requirement was made in relation to wound management documentation and one recommendation was made regarding the location of supplementary care records when not in use.

Is care compassionate?

There was evidence of good communication in the home between staff and patients. Patients and their representatives were very praiseworthy of staff and a number of their comments are included in the report.

Is the service well led?

Many compliments had been received by the home in relation to the care and compassion provided to patients/relatives and some of these comments are contained within this report. Appropriate certificates of registration and public liability insurance were on display. Two recommendations were made in this domain regarding auditing of patient care records and inclusion of staff feedback within monthly monitoring visits and reports.

The term ‘patients’ is used to describe those living in Cove Manor which provides both nursing and residential care.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	**3**	**4**

Details of the Quality Improvement Plan (QIP) within this report were discussed with Madge Quinn, Registered Manager, and Sean McCartney, Registered Person, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 18 April 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Sean McCartney Cove Manor Care Home Ltd	**Registered manager:** Madge Quinn
Person in charge of the home at the time of inspection: Madge Quinn	**Date manager registered:** 1 December 2010
Categories of care: RC-PH, RC-LD(E), NH-I, RC-I, RC-MP(E), RC-PH(E), NH-PH, NH-DE Category NH-DE for 3 identified patients only and category RC-LD(E) for 1 identified resident only. The home is also approved to provide care on a day basis only to 3 persons.	**Number of registered places:** 31

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the previous care inspection report and the returned QIP
- pre inspection assessment audit

During the inspection we met with10 patients individually and others in small groups, two patient representatives, three care staff and one ancillary staff member.

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspector.

Questionnaires were also left in the home to facilitate feedback from patients, their representatives and staff not on duty. Nine patient, nine staff and seven patient representative questionnaires were left for completion.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- three patient care records
- staff training records
- staff induction template
- complaints records
- incidents / accidents records since the last care inspection
- minutes of staff meetings
- a selection of audit documentation
- a staff recruitment file
- competency and capability assessments for nurse in charge
- monthly monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- duty rota for the period 10 October to 23 October 2016

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 18 April 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector and will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 28 September 2015

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 16 (2) **Stated:** Second time	The registered person must ensure that patients and resident's continence assessments be reviewed and updated appropriately to ensure that the patients and residents assessed needs are met.	**Met**
	Action taken as confirmed during the inspection: Three continence assessments reviewed had been reviewed and updated appropriately.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 19 Criteria (4) **Stated:** Second time	It is recommended that regular audits of the management of patients and residents who are incontinent be undertaken and the findings acted upon to enhance already good standards of care.	**Met**
	Action taken as confirmed during the inspection: A review of auditing documentation evidenced this recommendation has been met.	
Recommendation 2 **Ref:** Standard 36 Criteria (2) **Stated:** First time	It is recommended that policies on palliative and end of life care and death and dying be reviewed in line with current regional guidance, such as GAIN *Palliative Care Guidelines (2013).*	**Met**
	Action taken as confirmed during the inspection: A review of the policies as named above evidenced reference made to current best practice guidelines.	

Recommendation 3 **Ref:** Standard 46 Criteria (1) (2) **Stated:** First time	It is recommended that robust systems are in place to ensure compliance with best practice in infection prevention and control within the home. Particular attention should focus on the areas identified on inspection.	**Met**
	Action taken as confirmed during the inspection: Regular audit activity and monthly spot checks had been conducted from the last inspection. Good compliance with infection prevention and control within the home had been achieved.	
Recommendation 4 **Ref:** Standard 4 Criteria (9) **Stated:** First time	It is recommended that repositioning charts contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning.	**Met**
	Action taken as confirmed during the inspection: A review of five repositioning charts evidenced a clear record of skin checks were being maintained and reviewed.	
Recommendation 5 **Ref:** Standard 4.9 **Stated:** First time	It is recommended that bowel function, reflective of the Bristol Stool Chart is recorded on admission as a baseline measurement and thereafter in the patients'/residents' daily progress records.	**Met**
	Action taken as confirmed during the inspection: A review of three patient care records evidenced a comprehensive recording of individualised bowel management.	
Recommendation 6 **Ref:** Standard 35 Criteria (7) **Stated:** First time	It is recommended that regulation 29 monthly monitoring report is further developed to include unique identifiers of patients consulted. The report should include specific information rather than generalised statements.	**Met**
	Action taken as confirmed during the inspection: A review of the monthly monitoring reports evidenced that unique identifiers had been used to identify patients consulted.	

Recommendation 7 **Ref:** Standard 39 Criteria (1) **Stated:** First time	It is recommended that role specific induction booklets for registered nursing staff and for care staff are developed and completed as part of the induction programme.	**Met**
	Action taken as confirmed during the inspection: Role specific induction booklets had been developed and are now completed as part of the induction process.	

4.3 Is care safe?

A review of the staffing rota for the period 10 October to 23 October 2016 and discussion with the registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. Discussion with patients evidenced that there were no concerns regarding staffing levels. Observation of the delivery of care evidenced that patients' needs were met by the numbers and skill mix of staff on duty.

Discussion with staff and review of records confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. An induction booklet was completed and signed by the new employee and the staff member responsible for inducting the new employee.

Discussion with the registered manager and review of training records evidenced that a system was in place to monitor staff attendance at mandatory training. Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility. Compliance in mandatory training had been achieved, to date, in the following areas: moving and handling (86%), fire safety (85%), adult safeguarding (80%), first aid (83%) and infection prevention and control (85%). Observation of the delivery of care evidenced that training had been embedded into practice.

Competency and capability assessments of the nurse in charge of the home in the absence of the registered manager had been appropriately completed.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of current nursing and care staff with the Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC) were not appropriately managed. NMC checks were conducted annually and not, at minimum, the date of expiry. Confirmation was received from the registered person that all registered staff in the home were live on the NMC register. NISCC checks were maintained within a file. However, correspondence sent from NISCC to the home had not been evidenced to have been followed up by the home management. A requirement was made.

A review of the recruitment file for one recently employed staff member, evidenced a safe system was in practice. Relevant checks and interviews had been conducted prior to the staff member commencing in post.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding. Discussion with the registered manager confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process.

Review of notifications forwarded to RQIA from 28 September 2015 confirmed that these were appropriately managed. Accidents and incidents were reviewed monthly to identify any potential patterns or trends. Inspection of accident records evidenced that an unwitnessed fall had occurred. Records did not indicate that central nervous system (CNS) observations were taken immediately following the incident and monitored for a minimum of 24 hours. Records also did not indicate the persons informed of the fall and/or if medical advice had been requested. The accident records, relating to a second fall, where the patient's head struck a table during the fall were reviewed. A record of CNS observations was not evident within the records reviewed. A record of medical advice, requested if required, was also not available. This was discussed with the registered manager and a requirement was made to ensure post falls management was conducted in compliance with best practice guidance.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Bedrooms and communal areas were clean and spacious. Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were well maintained. However, damage was observed to shelving in the sluice. The glass within two fire exit doors was observed to be broken. Tiles within an identified bathroom were observed to be either missing or loose. This was discussed with the registered person and an assurance was given that the areas identified would be repaired/replaced accordingly. A recommendation was made. The loose tiles were removed immediately and arrangements had been made to replace them prior to the completion of the inspection.

Areas for improvement

It is required that all NMC and NISCC registrations within the home are checked and verified prior to the staff member lapsing from the professional register and at minimum the date of expiry.

It is required that post falls management is conducted in accordance with best practice guidance.

It is recommended that the environmental issues identified on inspection are appropriately remedied.

Number of requirements	2	**Number of recommendations**	1

4.4 Is care effective?

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process. Care plans had largely been personalised to meet the individual needs of the patients and had been reviewed monthly.

One issue arose during the review of patient care records pertaining to wound care management. Evidence was not present that registered nurses were adhering to regional guidelines. A wound assessment had not been completed. The wound care plan required further development to direct care required to meet the patient's wound care need. A requirement was made. A further recommendation was made in section 4.6 to ensure the quality of patient care records was maintained through the auditing process.

Supplementary documentation including food and fluid intake charts and bowel management charts had been completed well. However, some supplementary records were located on patients' side tables in communal areas and accessible by any persons walking through the communal areas. A recommendation was made to ensure the appropriate storage of records in accordance with professional guidance in patient confidentiality. Patient care records were stored within a lockable office.

Registered nurses were aware of the local arrangements and referral process to access relevant healthcare professionals, for example General Practitioner's (GP), speech and language therapist (SALT), dietician and tissue viability nurse (TVN).

Discussion with staff and the registered manager confirmed that general staff meetings were conducted regularly. There was evidence of a meeting conducted on 13 July 2016. Minutes of the meeting were available, maintained within a file and included details of attendees; dates; topics discussed and decisions made. The registered manager also confirmed that patient meetings were conducted regularly. Minutes of patients' meetings conducted on 10 March 2016 and 15 July 2016 were reviewed on inspection and had been completed appropriately.

The registered manager confirmed that they operate an 'open door policy' and are available to discuss any issues with staff, patients and/or relatives. The registered manager also confirmed that they would undertake a daily walk around the home and would avail of the opportunity to engage with patients and relatives at this time.

Discussion with the registered manager confirmed that surveys were completed by patients/relatives on an annual basis to provide feedback on services offered by the home.

Staff consulted knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Patients and representatives were confident in raising any concerns they may have with the staff and/or management.

Areas for improvement

It is required that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance.

It is recommended that supplementary care records are stored in accordance with professional guidance in patient confidentiality.

Number of requirements	1	Number of recommendations	1

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent with the exception of the daily charts issue in which a recommendation was made.

On inspection three carers and two ancillary staff members were consulted to ascertain their views of life in Cove Manor.

Some staff comments were as follows:
"It's a very homely home."
"It's a really nice environment to work in."
"I love it here."
"It's just like a big family."

Nine staff questionnaires were left in the home to facilitate feedback from staff not on duty on the day of inspection. None of the questionnaires were returned within the timescale for inclusion in the report.

Patients confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately. Consultation with 10 patients individually, and with others in smaller groups, confirmed that, in their opinion, the care was safe, effective, compassionate and well led. Nine patient questionnaires were left in the home for completion. Four patient questionnaires were returned within the timeframe.

Some patient comments were as follows:
"Life's good here. I'm happy."
"It's marvellous, no matter what you want you get."
"It's very good. I have no problems here."
"It is very good here. We are spoilt rotten."
"It is great and the food is great."
"It's alright here."
"Very very good."

Three patient representatives were consulted with on the day of inspection. Seven relative questionnaires were left in the home for completion. Three relative questionnaires were returned within the timeframe.

Some relative comments were as follows:
"We couldn't be happier with this nursing home."
"Always met with a warm welcome and we have no concerns when we leave."
"They (the staff) are great people and great workers. When … is happy, we are happy."

The serving of lunch was observed in the main dining room. The mealtime was well supervised. Staff wore appropriate aprons when serving or assisting with meals and patients were provided with dignified clothing protectors. Adequate spacing was observed between the patients seated at tables. A selection of condiments was available on the tables and a range of drinks were offered to the patients. The food was served from a kitchen hatch when patients were ready to eat or be assisted with their meal. A list of patients' special dietary requirements was maintained within the kitchen. The food appeared nutritious and appetising. A menu was on display on a noticeboard at the entrance to the dining room. Patients were observed to enjoy their meals.

Discussion with the registered persons and staff confirmed that the religious needs of patients were met through a religious service conducted in the home on a monthly basis. Services were also conducted at Easter and Christmas time. Staff also confirmed that members of the clergy come to the home to visit patients and that Eucharistic ministers attend the home every Sunday.

Responses from annual surveys were included within the annual quality report.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities.

The registration certificate was up to date and displayed appropriately. A certificate of public liability insurance was current and displayed. Discussion with the registered manager evidenced that the home was operating within its registered categories of care.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

A compliments file was maintained to record and evidence compliments received. Some examples of compliments received are as follows:
"Thank you for looking after mum. The family really appreciated your kindness and thoughtfulness."
"We would like to thank all the staff for the really good care and kindness that they showed to … during his stay."
"I will always remember with fondness my stay at Mullanahoe road."

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately. However, following a review of the incidents book as stated in section 4.3 of this report, a requirement was made regarding good practice in relation to post falls management.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, monthly audits were completed in accordance with best practice guidance in relation to continence management, accidents/incidents, fire, environment, kitchen and infection prevention and control. There was no evidence that patient care records had been audited. A recommendation was made to develop, conduct and maintain a record of patient care record audits.

Urgent communications, safety alerts and notices were reviewed by the registered manager on receipt and, where appropriate, were shared with staff. A system was in place to ensure that all relevant staff had read the communication or had been notified about it.

Discussion with the registered manager and review of records evidenced that monthly monitoring reports had been completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. However, in four reports, there was no evidence of any consultation with the home's staff. Also, an action plan, were appropriate, had not been completed to address any shortfalls identified within the reports. A recommendation was made. Copies of the reports were available for patients, their representatives, staff and trust representatives.

Areas for improvement

It is recommended that patient care records are audited to ensure record keeping is maintained in accordance with professional guidance.

It is recommended that the monthly monitoring visits conducted by the provider allow for feedback from staff in the home and this feedback is included within the monthly monitoring report. Where appropriate an action plan should be included within the report to address any shortfalls identified on the visit.

Number of requirements	0	**Number of recommendations**	2

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Madge Quinn, registered manager and Sean McCartney, registered person, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that 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 the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan	
Statutory requirements	
Requirement 1 **Ref:** Regulation 19 (2) Schedule 4 (6)(a) **Stated:** First time **To be completed by:** 19 October 2016	The registered person must ensure that all staffs NMC and NISCC registrations within the home are checked and verified prior to the staff member lapsing from the professional register and at minimum the date of expiry. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: NMC and NISCC are checked monthly for pending expirations. Staff are informed if their registration is due to expire.They are also reminded that a current registration is a requirement of employment.
Requirement 2 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time **To be completed by:** 30 November 2016	The registered person must ensure good practice guidance is adhered to with regard to post falls management. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Post falls management now includes documented monitoring of any resident who has a fall.
Requirement 3 **Ref:** Regulation 19 (1) (a) Schedule 3 (1) (a) (b) (3) (K) **Stated:** First time **To be completed by:** 30 November 2016	The registered person must ensure that record keeping in relation to wound management is maintained appropriately in accordance with legislative requirements, minimum standards and professional guidance. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: Wound management includes documenting of observations and actions taken.

Recommendations	
Recommendation 1 **Ref**: Standard 44 Criteria (1) **Stated:** First time **To be completed by:** 31 December 2016	The registered person should ensure that the areas identified on inspection are repaired/replaced as appropriate. **Ref: Section 4.3**
	Response by registered provider detailing the actions taken: Ongoing - necessary repairs and or replacement are in progress
Recommendation 2 **Ref**: Standard 37 Criteria (5) **Stated:** First time **To be completed by:** 30 October 2016	The registered person should ensure that supplementary care records are stored in accordance with professional guidance in patient confidentiality. **Ref: Section 4.4**
	Response by registered provider detailing the actions taken: supplementary care records such as fluid balance charts are stored in a manner that maintains confidentiality.
Recommendation 3 **Ref**: Standard 35 Criteria (3) **Stated:** First time **To be completed by:** 31 December 2016	The registered person should ensure that patient care records are audited to ensure record keeping is maintained in accordance with professional guidance. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: An additional auditing form has been added to each residents file. This will document monthly audits of each file to ensure that all the ncessary records are in place as per the residents file index (which is a list of all recommended records required in a residents file).This will include comments on any records not in file or that needs updating.
Recommendation 4 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 30 November 2016	The registered person should ensure that the monthly monitoring visits conducted by the provider allow for feedback from staff in the home and this feedback is included within the monthly monitoring report. Where appropriate an action plan should be included within the report to address any shortfalls identified on the visit. **Ref: Section 4.6**
	Response by registered provider detailing the actions taken: Staff feedback will be included in the owners monthly report. If necessary an action plan will be included. This action plan will include the person responsible for the action plan and a deadline.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address*

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