Unannounced Care Inspection Report
11 April 2019

Cove Manor

Type of Service: Nursing Home
Address: 89 Mullanahoe Road, Ardboe, Dungannon BT71 5AU
Tel No: 02886736349
Inspector: Dermot Walsh

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 18 patients.

3.0 Service details

Organisation/Registered Provider: Cove Manor Care Home Ltd **Responsible Individual:** Sean McCartney	**Registered Manager and date registered:** Madge Quinn – 1 December 2010
Person in charge at the time of inspection: Madge Quinn	**Number of registered places:** 18 Category NH-DE for 3 identified patients only and category NH-MP for 1 identified patient only. The home is also approved to provide care on a day basis only to 3 persons.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 18

4.0 Inspection summary

An unannounced inspection took place on 11 April 2019 from 09.30 hours to 16.30 hours.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to staffing arrangements, staff recruitment, induction, supervision and appraisal, risk assessment and the mealtime experience. Further good practice was found in relation to the delivery of compassionate care and maintaining good working relationships.

Areas requiring improvement were identified in relation to diet related training, the auditing of care records, compliance with Control of Substances Hazardous to Health legislation and compliance with infection prevention and control best practice guidelines.

Patients described living in the home in positive terms. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with staff.

Comments received from patients, the people who visit them and staff during and after the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	*2	2

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

Details of the Quality Improvement Plan (QIP) were discussed with Madge Quinn, registered manager and Sean McCartney, responsible individual, 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.

4.2 Action/enforcement taken following the most recent inspection dated 16 January 2019

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

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings, registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients and people who visit them about their experience of the home.
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home.
- observe practice and daily life.
- review documents to confirm that appropriate records are kept.

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire to give their views on the running of the home.

A poster indicating that an inspection was taking place was displayed at the entrance to the home and invited visitors to speak with the inspector.

The following records were examined during the inspection:

- duty rota for all staff week commencing 1 April 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one staff recruitment file
- four patient care records
- a sample of governance audits/records
- complaints record
- compliments received
- a sample monthly monitoring reports from January 2019
- RQIA registration certificate

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 16 January 2019

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

6.2 Review of areas for improvement from the last care inspection dated 20 September 2018

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 19 (2) **Stated:** First time	The registered person shall ensure that a record is maintained of all visitors to the home.	**Met**
	Action taken as confirmed during the inspection: A visitor's book was in place to record the identities of visitors to the home.	

Area for improvement 2 **Ref**: Regulation 27 (4) (b) **Stated:** First time	The registered person shall ensure that the working practices in the laundry are safe and do not present a fire risk. This is in relation to the taping of plugs to electrical sockets.	**Met**
	Action taken as confirmed during the inspection: All tape had been removed from plugs in the laundry and plugs were visible for inspection.	
Area for improvement 3 **Ref**: Regulation 14 (2) (a) (c) **Stated:** First time	The registered person shall ensure that all chemicals are securely stored in keeping with COSHH legislation to ensure that patients are protected from hazards to their health.	**Not met**
	Action taken as confirmed during the inspection: Multiple chemicals were observed accessible to patients in two separate areas in the home. This area for improvement has not been met and has been stated for a second time.	
Area for improvement 4 **Ref**: Regulation 16 **Stated:** First time	The registered person shall ensure that person centred care plans are developed in a timely manner from admission and reviewed as required to ensure that the care directed is current.	**Met**
	Action taken as confirmed during the inspection: A review of a recently admitted patient's care records evidenced that the patient's care plans had been developed in a timely manner.	
Area for improvement 5 **Ref**: Regulation 30 **Stated:** First time	The registered person shall ensure that all notifiable events are reported to RQIA in a timely manner from the date of the incident.	**Met**
	Action taken as confirmed during the inspection: A review of notifiable incidents in the home evidenced that RQIA had been notified appropriately.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref**: Standard 6 **Stated:** Second time	The registered person shall ensure that net pants are labelled for individualised patient use and unnamed net pants are not laundered and used communally.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of the environment evidenced that net pants in the home were single use only and disposed of appropriately following each use.	
Area for improvement 2 **Ref**: Standard 7 **Stated:** Second time	The registered person shall ensure that the complaints procedure for the home is in accordance with legislation and DHSSPS guidance on complaints.	**Met**
	Action taken as confirmed during the inspection: A review of the complaints procedure evidenced that this had been reviewed to reflect DOH guidance on complaints.	
Area for improvement 3 **Ref**: Standard 13 **Stated:** First time	The registered person shall ensure that the home's adult safeguarding policy is updated to reflect regional guidelines. Training pertinent to the role of the adult safeguarding champion must be sourced for the person identified in the role.	**Met**
	Action taken as confirmed during the inspection: A review of the safeguarding policy evidenced that this had been updated to reflect regional guidelines. Three staff had attended the adult safeguarding champion training.	
Area for improvement 4 **Ref**: Standard 37 **Stated:** First/ time	The registered person shall ensure that all records in the home are stored in accordance with legislative requirements and best practice guidelines.	**Met**
	Action taken as confirmed during the inspection: Records in the home were observed to have been stored correctly.	

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered manager confirmed that the number of staff and the skill mix of staff on duty at any given time was determined through regular monitoring of patient dependency levels in the home. A review of the duty rota for week commencing 1 April 2019 confirmed that the planned staffing level and skill mix was adhered too. Rotas also confirmed that catering and housekeeping were on duty daily to meet the needs of the patients and to support the care staff. Patients' needs and requests for assistance were observed to have been met in a timely and caring manner. Patients and their visitors consulted spoke positively in relation to the care provision in the home. Discussion with staff confirmed that they were satisfied that patients' needs were met with the planned staffing level and skill mix.

A review of one staff's recruitment records confirmed that the appropriate pre-employment checks had been completed prior to the staff member commencing in post. References had been obtained and records indicated that Access NI checks had been conducted. Regular checks were made on registered nurses to ensure that they maintained their registration with the Nursing and Midwifery Council (NMC). Similar checks were made on care workers to ensure that they were on the Northern Ireland Social Care Council (NISCC) register and that no restrictions to their employment had been identified. New care staff were required to join the NISCC register as soon as possible following commencement of employment.

Staff consulted confirmed that they completed a structured orientation and induction programme when they commenced employment in the home. Staff confirmed that supernumerary hours were allocated to them at the commencement of their employment. These are hours in which staff were not counted within staffing numbers on the duty rota. This would give new staff the opportunity to work alongside a more experienced member of the team in order to gain knowledge of the home's policies and procedures. Staff spoke positively in relation to the induction process. The registered manager confirmed that all nursing and care staff were also mentored and coached through supervision and appraisal. A system had been developed to ensure that all registered nursing and care staff employed received, at minimum, two recorded supervisions per year and one annual staff appraisal.

A record of any training that staff had completed was maintained in the home. Staff were satisfied that the training provided assisted them in their roles within the team. The registered manager confirmed that new electronic training was in the process of being implemented in the home. The registered manager also confirmed that practical, face to face training would also continue as required. Staff had been consulted in relation to the implementation of electronic training. Discussion with the registered manager and staff confirmed that training in using new International Dysphagia Diet Standardisation Initiative (IDDSI) indicators had not commenced. The implementation of IDDSI indicators was due to commence regionally in April 2019. An area for improvement was made.

An adult safeguarding champion had been identified to manage any potential safeguarding incidents. Recent training had been provided pertinent to this role. Discussion with the registered manager confirmed that they were aware of the regional safeguarding policy and procedures. Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns.

A review of three patients' care records evidenced that appropriate individualised risk assessments were completed on each patient at the time of their admission. Risk assessments had been reviewed regularly and care plans had been developed which were reflective of the risk assessments. Care plans had also been reviewed and updated regularly.

We reviewed the home's environment undertaking observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. Fire exits and corridors were observed to be clear of clutter and obstruction. Stairwells were also observed to be clear. The home was clean and fresh smelling. Patients were seated in the open reception area, one of the lounges or in their bedroom as was their choice. Patients were complimentary in regards to the environment and the surrounding areas. However, two areas in the home were observed where multiple chemicals were accessible to patients. This was discussed with the registered manager and an area for improvement in this regard, made at the previous care inspection, was stated for the second time. Areas were also identified in the home which were not in compliance with best practice on infection prevention and control (IPC) guidelines. This was discussed with the registered manager and identified as an area for improvement.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing arrangements, staff recruitment, induction, supervision and appraisal.

Areas for improvement

The following areas were identified for improvement in relation to IDDSI training and IPC compliance. An area for improvement in relation to compliance with Control of Substances Hazardous to Health (COSHH) legislation has been stated for the second time

	Regulations	Standards
Total numb of areas for improvement	1	1

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

There was evidence within four patients' care records reviewed that appropriate risk assessments were completed on admission and reviewed on a regular basis. Risk assessments had been completed on falls management, nutrition, pressure management and restrictive practice. Care plans had been developed which were reflective of the risk assessments. The care plans had also been reviewed regularly or as the patients' needs changed. Registered nursing staff confirmed that there were no wounds in the home requiring dressing.

Two of the records reviewed contained care plans which were no longer relevant and contained other records which had been documented in 2016 and 2017. It was also observed that a care record audit had not been completed. This will be further discussed in Section 6.7.

Patients had been weighed regularly and a nutritional screening tool known as Malnutrition Universal Screening Tool (MUST) was implemented to determine the risk of weight loss or weight gain. Where a risk was identified there was evidence within patients' care records that advice was sought from an appropriate health professional, such as a dietician. Patient care records also evidenced that advice received from health professionals were incorporated within the patients' care plans.

Patients and staff confirmed that they had 24 hour access to food and fluids. Patients and staff commented positively on the food provision. We reviewed the lunchtime meal experience during the inspection. The meal commenced around 12.30 hours. Patients dined in the main dining room on the ground floor or at their preferred dining area. A menu was displayed at the entrance to the dining room and individual menus were available on patients' dining tables reflective of the food which was served. Food was served directly from the kitchen when patients were ready to eat or be assisted with their meal. The food served appeared nutritious and appetising. Staff were knowledgeable in relation to patients' dietary requirements. Patients wore clothing protectors where required and staff wore aprons when serving or assisting with meals. Staff were observed chatting with patients when assisting with meals and patients were assisted in an unhurried manner. Patients consulted confirmed that they enjoyed the meal.

Patients' risk of pressure related skin damage was assessed on their admission and reviewed on a monthly basis. When a risk was identified, such as immobility, poor diet or incontinence; a care plan was developed to guide staff in measures to prevent skin breakdown. There was evidence that when a wound was identified, an initial wound assessment would have been completed and a wound care plan developed to direct the care in managing the wound. Body maps were completed identifying the location of the wound and wound observation charts completed to monitor the progress of the wound at the time of wound dressing. There was also evidence of referrals made to the tissue viability nurse for professional advice where a wound was not healing as expected.

Falls in the home were monitored on a monthly basis for any patterns and trends in times or locations of the fall. This would be to review the pattern to proactively plan measures to reduce the incidences of falls where possible. Accident records were maintained following any fall in the home.

When a restrictive practice, such as the use of bedrails or an alarm mat had been implemented, there was evidence within the patient's care records of an initial assessment completed to ensure safe use. This assessment was reviewed regularly. There was evidence of communication with the patient's next of kin in relation to use of the restrictive practice and a consent/discussion form had been signed by the next of kin. The assessed need for the restrictive practice was included within the patient's care plans and there was evidence that the continued need for the use of restrictive practice was monitored.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to risk assessment and the mealtime experience.

Areas for improvement

No areas for improvement were identified during the inspection in the effective domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff were aware of individual patients' wishes, likes and dislikes. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were given choice, privacy, dignity and respect. Staff were also aware of patient confidentiality regarding the handling and use of patient information.

The environment had been adapted to promote positive outcomes for the patients. Bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences.

Consultation with eight patients individually, and with others in smaller groups, confirmed that living in Cove Manor was a positive experience. Patient questionnaires were left for completion. Two were returned within the timeframe. Both respondents indicated that they were satisfied or very satisfied that the home provided safe, effective, compassionate care and that the home was well led.

Patient comments:

"Staff are very good to me. Dinner is very good."
"I find everything good here."
"The staff are really nice and the foods good."
"I like it here."
"It's very good here. Staff are good."
"You get very good care here."
"This place is good."

One patient's relative was consulted during the inspection. The relative spoke positively in relation to the care delivery and dedication of the staff. Patient representatives' questionnaires were left for completion. One was returned. The respondent indicated that they were very satisfied with the care delivery in the home.

One questionnaire was returned which did not indicate if it was from a patient or a visitor. The respondent indicated that they were very satisfied that the home provided safe, effective, compassionate care and that the home was well led.

Staff were asked to complete an online survey; we had no responses within the timescale specified. Comments from six staff consulted during the inspection included:

"It's grand here. Nice atmosphere."
"Everyone gets on well. Patients enjoy the craic with staff."
"We are always quite busy but it's good."
"I've had my own relatives in. That says it all."
"I love working here."

Any comments from patients, patient representatives and staff in returned questionnaires or online responses received after the return date will be shared with the registered manager for their information and action, as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the delivery of compassionate care.

Areas for improvement

No areas for improvement were identified during the inspection in the compassionate domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. This certificate identifies the management arrangements for the home and the maximum number of patients allowed to be accommodated in the home. Since the last care inspection, the management arrangements in the home had not changed. Discussion with the registered manager and staff, and observations confirmed that the home was operating within its registered categories of care.

Staff confirmed that the registered manager was always available to provide guidance or advice during and out of normal office hours. Patients confirmed that they were aware of who the registered manager was and spoke positively in relation to interactions with the home's management. A review of the duty rota clearly evidenced the identity of the nurse in charge of the home in the absence of the registered manager.

The registered manager confirmed that they had not received any recent complaints in the home relating to patients' care or in relation to the provision of any service in the home. A system was in place to record any complaints received including all actions taken in response to the complaint. Patients and their visitors consulted during the inspection confirmed that they would have no issues in raising any identified concern with the home's staff or management. A complaints procedure was available to assist patients or their visitors to make a complaint if required.

Discussion with the registered manager and review of auditing records evidenced that a number of audits were completed to assure the quality of care and services. For example, audits were completed regarding accidents/incidents, wound care, restrictive practices and infection prevention and control practices. There were no recent care record audits available. Given the findings in the two patient care records, as identified in Section 6.5, this was discussed with the registered manager and identified as an area for improvement.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to complaints management, management of incidents and maintaining good working relationships.

Areas for improvement

An area for improvement was identified in relation to the auditing of patient care records.

	Regulations	Standards
Total number of areas for improvement	0	1

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Madge Quinn, registered manager and Sean McCartney, responsible individual, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

A completed Quality Improvement Plan from the inspection of this service has not yet been returned.

If you have any further enquiries regarding this report please contact RQIA through the e-mail address info@rqia.org.uk

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation 14 (2) (a) (c) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that all chemicals are securely stored in keeping with COSHH legislation to ensure that patients are protected from hazards to their health. Ref: 6.2 and 6.4
	Response by registered person detailing the actions taken:
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** 11 May 2019	The registered person shall ensure the infection prevention and control issues identified on inspection are managed to minimise the risk and spread of infection. A more robust system should be in place to ensure compliance with best practice on infection prevention and control. Ref: 6.4
	Response by registered person detailing the actions taken:
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 39 **Stated:** First time **To be completed by:** 30 June 2019	The registered person shall ensure that IDDSI training is conducted with all staff in the home involved with the provision of food. Care records shall make reference to IDDSI descriptors. Ref: 6.4
	Response by registered person detailing the actions taken:
Area for improvement 2 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 31 May 2019	The registered person shall ensure that patients' care records are audited on a regular basis. Ref: 6.6
	Response by registered person detailing the actions taken:

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

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