Announced Primary Inspection

Name of Establishment:	**Cove Manor Private Nursing Home**
Establishment ID No:	**1419**
Date of Inspection:	**23 April 2014**
Inspector's Name:	**Heather Moore**
Inspection No:	**16492**

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh
Tel: 028 8224 5828 Fax: 028 8225 2544

1.0 General Information

Name of Home:	Cove Manor Private Nursing Home.
Address:	89 Mullanahoe Road Ardboe Dungannon BT71 5AU
Telephone Number:	028 8673 6349
E mail Address:	office@covemanor.co.uk
Registered Organisation/ Registered Provider:	Cove Manor Care Home Ltd Mr Sean McCartney
Registered Manager:	Mrs Madge Quinn
Person in Charge of the Home at the time of Inspection:	Mrs Madge Quinn
Registered Categories of Care and number of places:	NH-PH, NH-I, NH-DE, RC-I, RC-MP(E), RC-PH(E) 31
Number of Patients/Residents Accommodated on Day of Inspection:	20-Patients 9-Residents
Date and time of this inspection :	23 April 2014 08.20 hours to 14.45 hours
Date and type of previous inspection:	29 September 2013 Secondary unannounced

2.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is empowered under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to inspect nursing homes. A minimum of two inspections per year is required.

This is a report of a primary inspection to assess the quality of services being provided. The report details the extent to which the standards measured during inspection were met.

3.0 Purpose of the Inspection

The purpose of this inspection was to consider whether the service provided to patients was in accordance with their assessed needs and preferences and was in compliance with legislative requirements, minimum standards and other good practice indicators. This was achieved through a process of analysis and evaluation of available evidence.

RQIA not only seeks to ensure that compliance with regulations and standards is met but also aims to use inspection to support providers in improving the quality of services. For this reason, inspection involves in-depth examination of an identified number of aspects of service provision.

The aims of the inspection were to examine the policies, practices and monitoring arrangements for the provision of nursing homes, and to determine the provider's compliance with the following:

- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- The Nursing Homes Regulations (Northern Ireland) 2005
- The Department of Health, Social Services and Public Safety's (DHSSPS) Nursing Homes Minimum Standards (2008)

Other published standards which guide best practice may also be referenced during the Inspection process.

4.0 Methods/Process

Committed to a culture of learning, the RQIA has developed an approach which uses self-assessment, a critical tool for learning, as a method for preliminary assessment of achievement of the DHSSPS Nursing Homes Minimum Standards 2008.

The inspection process has three key parts; self-assessment (including completion of self declaration), pre-inspection analysis and the inspection visit by the inspector.

Specific methods/processes used in this inspection include the following:

- analysis of pre-inspection information
- discussion with the registered providers
- discussion with the registered manager

- examination of records
- consultation with stakeholders
- tour of the premises
- evaluation and feedback.

Any other information received by RQIA about this registered provider has also been considered by the inspector in preparing for this inspection.

5.0 Consultation Process

During the course of the inspection, the inspector spoke with:

Patients	**Six individually and with others in groups**
Staff	**10**
Relatives	**1**
Visiting Professionals	**0**

Questionnaires were provided, during the inspection, to patients, their representatives and staff to seek their views regarding the service. Matters raised from the questionnaires were addressed by the inspector in the course of this inspection.

Issued To	**Number issued**	**Number returned**
Patients	**4**	**4**
Relatives / Representatives	**1**	**1**
Staff	**10**	**10**

6.0 Inspection Focus

The inspection sought to establish the level of compliance achieved regarding the selected DHSSPS Nursing Homes Minimum Standards. An assessment on the progress of the issues raised during and since the previous inspection was also undertaken.

Standards inspected:

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed. (Selected criterion)

Standard 8: Nutritional needs of patients are met. (Selected criterion)

Standard 11: Prevention and treatment of pressure ulcers. (Selected criterion)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criterion)

The focus of inspection within these standards will be based on three areas of practice or 'themes' as follows:

- Management of Nursing Care – Standard 5
- management of Wounds and Pressure Ulcers –Standard 11
- management of Nutritional Needs and Weight Loss – Standard 8 and 12
- management of Dehydration – Standard 12

There will be an overarching view of the management of patient's human rights - Patients' individual and human rights are safeguarded and actively promoted within the context of services delivered by the home.
The registered persons and the inspector have rated the home's compliance level against each criterion and also against each standard.

The table below sets out the definitions that RQIA has used to categorise the service's performance:

Guidance - Compliance statements		
Guidance - Compliance statements	**Definition**	**Resulting Action in Inspection Report**
0 - Not applicable		A reason must be clearly stated in the assessment contained within the inspection report
1 - Unlikely to become compliant		A reason must be clearly stated in the assessment contained within the inspection report
2 - Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
3 - Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the Inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report
4 - Substantially Compliant	Arrangements for compliance were demonstrated during the inspection. However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation, or in some circumstances a requirement, being made within the inspection report
5 - Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.

7.0 Profile of Service

Cove Manor is situated in the village of Ardboe, County Tyrone. It is close to local shops, Churches, and the Community Parish Centre.

The home is registered to care for people in the following categories of care:

Nursing Care

- NH - I: Old age not falling within any other category
- NH - PH: Physical Disability other than sensory impairment
- NH - DE: Dementia Nursing (3 identified patients)

Residential Care

- RC - I - Old age not falling within any other category
- RC - MP (E) - Mental Disorder excluding learning disability over 65 years
- RC - PH (E) - Physical Disability other than sensory impairment

The home is also approved to provide day care for three service users.

Cove Manor comprises of the following, a number of single and double bedrooms, choice of sitting rooms, conservatory, visitors room, dining room, washing/toilet facilities, kitchen, laundry, staff accommodation and offices.

There is adequate car parking facilities in the grounds of the home.

The certificate of registration issued by the Regulation and Quality Improvement Authority (RQIA) accurately reflected the categories of care and was appropriately displayed in a prominent position of the home.

8.0 Summary of Inspection

This announced primary care inspection of Cove Manor was undertaken by Heather Moore inspector, on 23 April 2014 from 08.20 hours to 14.45 hours.

The inspector was welcomed into the home by Mrs Madge Quinn Registered Manager. The registered manager was available throughout the inspection and facilitated the process. Verbal feedback of the issues identified during the inspection was given to Mrs Quinn Registered Manager and Mr Sean McCartney Registered Provider at the conclusion of the inspection.

Prior to the inspection, the registered persons completed a self-assessment using the criteria outlined in the standards inspected. The comments provided by the registered persons in the self-assessment were not altered in any way by RQIA. See appendix one. The inspector spoke to ten patients and residents individually and with others in groups.
During the inspection, the inspector met with patients, residents, one relative and 10 staff.
The inspector observed care practices, examined a selection of records and carried out a general inspection of the nursing home environment as part of the inspection process.
Questionnaires were issued to patients / residents, relatives/ representatives and staff during the inspection.

The inspector spent a number of extended periods observing staff and patient interaction. Discussions and questionnaires are unlikely to capture the true experiences of those patients unable to verbally express their opinions. Observation therefore is a practical and proven method that can help us to build up a picture of their care experience.

These observations have been recorded using the Quality of Interaction Schedule (QUIS). This tool is designed to help evaluate the type and quality of communication which takes place in the nursing home.

As a result of the previous inspection conducted on 29 September 2013. Two recommendations were issued. These were reviewed during this inspection. The inspector evidenced that the recommendations had been complied with. Details can be viewed in the section immediately following this summary.

Standards inspected:

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed. (Selected criteria)

Standard 8: Nutritional needs of patients are met. (Selected criteria)
Standard 11: Prevention and treatment of pressure ulcers. (Selected criteria)

Standard 12: Patients receive a nutritious and varied diet in appropriate surroundings at times convenient to them. (Selected criteria)

Inspection Findings.

- **Management of Nursing Care – Standard 5**

The inspector can confirm that at the time of the inspection there was evidence to validate that patients and residents receive safe and effective care in Cove Manor Private Nursing Home.
There was evidence of comprehensive and detailed assessment of patient and resident needs from date of admission. This assessment was found to be updated on a regular basis and as required. A variety of risk assessments were also used to supplement the general assessment tool.
Comprehensive reviews of the assessments of need, the risk assessments and the care plans were maintained on a regular basis plus as required.
There was also evidence that the referring HSC Trust maintained appropriate reviews of the patient's satisfaction with the placement in the home and the quality of care delivered however one patient's annual care management review was not carried out on an annual basis and the registered manager had made efforts to the relevant Trust to address this issue.

- **Management of Wounds and Pressure Ulcers –Standard 11**

The inspector evidenced that wound management in the home was well maintained. There was evidence of appropriate assessment of risk of development of pressure ulcers which demonstrated timely referral to Tissue Viability professionals for guidance and pressure relieving equipment. Care plans for the management of risks of pressure ulcers and wound care were maintained to a professional standard.
A recommendation is made that the pressure relieving equipment in use on patients 'and residents' beds and when sitting out of bed be addressed in patients' and residents' care plans on pressure area care and prevention.

- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**

The inspector reviewed the management of nutrition and weight loss within the home.
Robust systems were evidenced with risk assessments and appropriate referrals to GP's, speech and language therapists and or dieticians being made as required.
A requirement is made that the recommendations made by the Speech and Language Therapist are recorded in the patients' care plans on eating and drinking,

The inspector also observed the serving of the lunch meal and can confirm that the patients were offered a choice of meal and that the meal service was well delivered. Patients were observed to be assisted with dignity and respect throughout the meal.
A recommendation is made that the menu planner be reviewed to include choices for snacks for patients' and residents' on therapeutic diets.

- **Management of Dehydration – Standard 12**

The inspector also examined the management of dehydration during the inspection. The home was evidenced to identify fluid requirements for patients and records were maintained of the fluid intake of those patients assessed at risk of dehydration. Patients were observed to be able to access fluids with ease throughout the inspection.

The inspector can confirm that based on the evidence reviewed, presented and observed; that the level of compliance with this standard was assessed as substantially compliant.

Patients / their representatives and staff questionnaires.

Some comments received from patients and their representatives;

"I enjoy the food that I am given in the home."
"The staff here are very helpful."
"The food here is very good."
"I always have access to my buzzer."
"I like living here."
"I am always offered a choice of food and drink."
"My mother is well looked after."

Some comments received from staff;

"Yes I have had training in the recording of food and fluid intake charts."
"It's a very friendly nursing home and everyone works to their best ability."
"Everyone works well together and provides the best care possible."
"It's a very welcoming nursing home, all nurses, management, and care assistants always try their best to be accommodating to all of the residents wishes."
"I think each care assistant try's their best to care for individual in the home at all times."
"I find that the care delivered in Cove Manor is of the highest standards and all staff give the best care possible."
"Residents needs are catered for and their independence and dignity are protected."
"Residents are treated with respect and dignity by all the staff."
"The staff are all very happy working here and are always pleasant and happy at their work."

A number of additional areas were also examined

- Records required to be held in the nursing home
- Patients Under Guardianship
- Human Rights Act 1998 and European Convention on Human Rights (ECHR) DHSSPS and Deprivation of Liberty Safeguards (DOLS)
- General environment
- Patients/residents/their representatives and staff questionnaires.

Conclusion

The inspector evidenced that at the time of inspection the delivery of care to patients and residents was evidenced to be of a good standard. There were processes in place to ensure the effective management of the themes inspected.

However areas for improvement were identified. Three requirements and two recommendations were made in respect of this inspection. Details can be viewed in the main body of the report and in the Quality Improvement Plan (QIP).

The inspector would like to thank the registered provider, registered manager, residents, patients, the visiting relative, registered nurses and staff for their helpful discussions and assistance throughout the inspection process.

The inspector would also like to thank the patients' residents' staff and the relative who completed questionnaires.

9.0 Follow-up on Previous Issues

No	Regulation Ref.	Requirement	Action taken - as confirmed during this inspection	Inspector's Validation of Compliance
1	20 (1) (a)	The registered person shall ensure that at all times suitably; qualified, competent persons are working at the nursing home in such numbers as are appropriate for the health and welfare of patients and residents. This requirement is made in regard to the shortfall of one registered nurse from 8am-2pm.	Inspection of three weeks duty rosters confirmed that registered nurses staffing levels were satisfactory and in line with the RQIA recommended staffing guidelines.	Compliant

No	Minimum Standard Ref.	Recommendations	Action Taken – as confirmed during this inspection	Inspector's Validation of Compliance
1	20.4	It is recommended that an evaluation of staff training on first aid and resuscitation is held in the home.	Inspection of staff training records confirmed that an evaluation on first aid and resuscitation was held in the home.	Compliant
2	20.4	It is recommended that records are held to evidence staff competencies in resuscitation.	Inspection of staff records confirmed that records were maintained to evidence staff competencies in resuscitation	Compliant
3	20.2	It is recommended that emergency equipment is checked daily (unless otherwise recommended by the manufacturer's instructions.	Inspection of the records of emergency equipment confirmed that the emergency equipment was checked daily.	Compliant
4	6.3	It is recommended that alterations in patients/residents care records are dated timed and signed appropriately.	Inspection of a sample of three patients care records confirmed that alterations were recorded appropriately	Compliant
5	34.1	In order to enhance infection control standards in the home it is recommended that suitable wipe able pull cords switches be provided throughout the home.	During a tour of the premises it was confirmed that suitable wipe able pull cord switches were provided throughout the home.	Compliant

10.0 Inspection Findings

Section A

Standard : 5.1

- **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment**

Standard 5.2

- **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission**

Standard 8.1

- **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent**

Standard 11.1

- **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

- **Management of Wounds and Pressure Ulcers –Standard 11**
- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**
- **Management of Dehydration – Standard 12**

Inspection Findings:

Policies and procedures relating to patients 'and residents' admissions were available in the home. These policies and procedures addressed pre-admission, planned and emergency admissions.

Review of these policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Home Minimum Standards (2008) and NMC professional guidance.

There was evidence to demonstrate that patients' and residents' individual needs were established on the day they were admitted to the nursing home, and effective procedures were in place to manage any identified risks.

The inspector reviewed three patients care records which evidenced that at the time of each patient's admission to the home, a registered nurse carried out initial risk assessments and developed agreed plans of care to meet the patient's and resident's immediate care needs.

Specific validated assessment tools such as moving and handling, Braden scale, Malnutrition Universal Screening Tool (MUST), falls, pain and continence were also completed on admission.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section B

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

- **Management of Wounds and Pressure Ulcers –Standard 11**
- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**
- **Management of Dehydration – Standard 12**

Standard 5.3

- **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.**

Standard 11.2

- **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.**

Standard 11.3

- **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.**

Standard 11.8

- **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration**

Standard 8.3

- **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16

Inspection Findings:

The inspector observed that a named nurse system was operational in the home.

Review of three patients care records and discussion with six patients /residents individually and one patient's representative evidenced that patients residents and/or their representatives had been involved in discussions regarding the agreeing and planning of nursing interventions. Records also evidenced discussion with patients and/or their representatives following changes to the plans of care.

In relation to wound care, the inspector examined one patient's care record.

Body mapping charts were completed for patients on admission. These charts were reviewed and updated when any changes occurred to the patients' skin conditions.

Care plans were in place for wound care however a care plan was not in place which specified the pressure relieving equipment in place on the patients' bed and also when sitting out of bed. A recommendation is made in this regard.

There was evidence that patients' had pressure relieving devices in place, and the type of mattress in use was based on the outcome of the pressure risk assessment.

Patients' moving and handling needs were assessed and addressed in their care plan. There was evidence that manual handling aids were used to minimise risk of friction. Staff consulted confirmed there was sufficient nursing equipment available to move and handle patients' appropriately.

Wound observation charts outlined the dimensions of wounds and were completed each time dressings were changed. Entries were also made in wound care records each time the dressings were changed.

A care plan based on the outcome of a pain assessment was not drawn up for one identified patient a requirement is made in this regard.

Discussion with one registered nurse, the registered manager and review of three patients care records confirmed that where a patient was assessed as being 'at risk' of developing a pressure ulcer, a care plan was in place to manage the prevention plan and treatment programme. Advice sought from the relevant healthcare professionals was recorded clearly and adhered to. Care records reflected advice provided by these professionals, and records reviewed demonstrated that the advice provided was adhered to.

The registered manager confirmed that there were referral procedures in place to obtain advice and guidance from tissue viability nurses in the local healthcare trust. Staff spoken with was knowledgeable regarding the referral process. Discussion with the registered

manager evidenced that she was knowledgeable of the action to take to meet the patients' needs in the interim while waiting for the relevant healthcare professional to assess the patient.

Review of the records of incidents revealed that the incidence of pressure ulcers, grade 2 and above was reported to the RQIA in accordance with Regulation 30 of the Nursing Home Regulations (Northern Ireland) 2005.

Patients' weights were recorded on admission and on at least a monthly basis or more often if required.

Daily records were maintained regarding patients daily food and fluid intake. Patients' recommended daily fluid intakes were recorded in their care plans.

Policies and procedures were in place for staff on making referrals to the dietician. These include indicators of the action to be taken and by whom.
Nursing staff spoken with were knowledgeable regarding the referral criteria for a dietetic assessment.

Three care records reviewed evidenced that patients were referred for dietetic assessment in a timely manner.

Examination of one care record confirmed that the recommendations provided by the speech and language therapist were not included in the respective patient's care plan. A requirement is made in this regard. Records examined were reviewed and evaluated on a regular basis.

Observation of practice and discussion with patients and staff evidenced that the nutritional care plans were being implemented.

Review of staff training records revealed that staff had received training on dysphagia on the 13 March 2013.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Moving Towards Compliance**

Section C

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

- **Management of Wounds and Pressure Ulcers –Standard 11**
- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**
- **Management of Dehydration – Standard 12**

Standard 5.4

- **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16

Inspection Findings:

Review of three patient care records revealed that re-assessment was an on-going process and was carried out daily or more often in accordance with the patients' needs. Day and night registered nursing staff recorded evaluations in the daily progress notes on the delivery of care including wound management for each patient.

Care plans including supplementary assessments were reviewed and updated on at least a monthly basis or more often if required.

Review of one patient's care record in relation to wound care and management of nutrition indicated that this care record was reviewed regularly.

The evaluation process included the effectiveness of any prescribed treatments, for example prescribed analgesia.

Discussion with the registered manager and review of governance documents evidenced that the quality of care records was audited on a monthly basis.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section D

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

- **Management of Wounds and Pressure Ulcers –Standard 11**
- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**
- **Management of Dehydration – Standard 12**

Standard 5.5

- **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.**

Standard 11.4

- **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.**

Standard 8.4

- **There are up to date nutritional guidelines that are in use by staff on a daily basis.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)

Inspection Findings:

The inspector examined three patients care records which evidenced the completion of validated assessment tools such as;

- the Roper, Logan and Tierney assessment of activities of daily living
- Braden pressure risk assessment tool
- Nutritional risk assessment such as the Community Nutritional Assessment Tool for Older People in Nursing Homes.

The inspector confirmed the following research and guidance documents were available in the home;

- The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes for Older People and for those providing community meals
- The National Institute for Health and Clinical Excellence (NICE) for the management of pressure ulcers in primary and secondary care
- The European Pressure Ulcer Advisory Panel (EPUAP).

Discussion with the registered manager confirmed that she had a good awareness of these guidelines. Review of three patients care records evidenced that registered nurses implemented and applied this knowledge.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. One registered nurse and two care staff consulted could identify patients who required support with eating and drinking.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section E

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

- **Management of Wounds and Pressure Ulcers –Standard 11**
- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**
- **Management of Dehydration – Standard 12**

Standard 5.6

- **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.**

Standard 12.11

- **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.**

Standard 12.12

- **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.**
  Where a patient is eating excessively, a similar record is kept
  All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25

Inspection Findings:

Review of policies evidenced that they were reflective of The Nursing Homes Regulations (Northern Ireland) 2005, DHSSPS Nursing Home Minimum Standards (2008) and NMC professional guidance.

Registered nurses spoken with were aware of their accountability and responsibility regarding record keeping.
Review of three patients care records confirmed that registered nursing staff on day and night duty recorded statements to reflect the care and treatment provided to each patient.

These statements reflected wound and nutritional management intervention for patients if required.

Additional entries were made throughout the registered nurses span of duty to reflect changes in care delivery, the patient's status or to indicate communication others concerning the patient.

Entries were noted to be dated, timed and signed with the signature accompanied by the designation of the signatory.

The inspector reviewed a record of the meals provided for patients. Records were maintained in sufficient detail which enabled the inspector to judge that the diet for each patient was satisfactory. For example, the record evidenced a choice at each mealtime.
Staff spoken with were knowledgeable regarding patients nutritional needs.

Discussion with the registered manager and review of governance documents evidenced that the quality of record management was in keeping with DHSSPS minimum standards and NMC guideline.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section F

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed. **The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:** • **Management of Wounds and Pressure Ulcers –Standard 11** • **Management of Nutritional Needs and Weight Loss – Standard 8 and 12** • **Management of Dehydration – Standard 12**
Standard 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**
Please refer to criterion examined in section E. In addition the review of patient care records evidenced that consultation with the patient and/or their representative had taken place in relation to the planning of their care. This is in keeping with the DHSSPS minimum standards and the Human Rights Act 1998.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section G

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.

The focus of inspection within Standard 5 will be based on three areas of practice or 'themes' as follows:

- **Management of Wounds and Pressure Ulcers –Standard 11**
- **Management of Nutritional Needs and Weight Loss – Standard 8 and 12**
- **Management of Dehydration – Standard 12**

Standard 5.8

- **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate**

Standard 5.9

- **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.**

Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)

The registered manager informed the inspector that care management reviews were held post admission and then annually thereafter. Reviews can also be arranged in response to changing needs, expressions of dissatisfaction with care or at the request of the patient or family. A member of nursing staff attends each review. A copy of the minutes of the most recent review was held in the patient's care record file.
Discussions with the registered manager revealed that one patient's care management review was not undertaken annually. The registered manager had made efforts with the relevant Trust to address this concern.

The inspector viewed the minutes of four care management reviews which evidenced that, where appropriate patients and their representatives had been invited to attend. Minutes of the review included the names of those who had attended an assessment of the patients' needs and a record of issues discussed. Care plans were updated to reflect recommendations made at care management reviews where applicable.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Compliant**

Section H

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Homes Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**
A policy and procedure was in place to guide and inform staff in regard to nutrition and dietary intake. The policy and procedure in place was reflective of best practice guidance. There was a four weekly menu planner in place. The registered manager informed the inspector that the menu planner had been reviewed and updated in consultation with patients, their representatives and staff in the home. The current menu planner was implemented on the 01 April 2014. The inspector discussed with the registered manager and a number of staff the systems in place to identify and record the dietary needs, preferences and professional recommendations of individual patients. Staff spoken with were knowledgeable regarding the individual dietary needs of patients to include their likes and dislikes. Discussion with staff and review of the record of the patient's meals confirmed that patients were offered choice prior to their meals. Staff spoken with were knowledgeable regarding the indicators for onward referrals to the relevant professionals, e.g. speech and language

therapist or dieticians.

As previously stated under Section B and review of one patient's care records evidenced that the patient was referred for a speech and language assessment in a timely manner. However, the speech and language therapist's recommendations were not addressed in the patient's care plan. A requirement is made in this regard.

Review of the menu planner and records of patients' choices and discussion with a number of patients, registered nurses and care staff it was revealed that choices were available at each meal time. The registered manager confirmed choices were also available to patients who were on therapeutic diets. A recommendation is made that the menu planner be reviewed to include choices for snacks for patients and residents on therapeutic diets.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

Section I

Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Homes Regulations (Northern Ireland)2005:Regulation/s13 (1) and 20**
The inspector discussed the needs of the patients with the registered manager. It was determined that a number of patients had swallowing difficulties. Review of training records revealed that staff had attended training in dysphagia awareness during the previous year and further training was planned. Review of one patients' care record who had been assessed by a speech and language therapist. The patient's care plan did not address speech and language therapist's recommendations. As previously stated a requirement is made in this regard.

Discussion with registered manager confirmed that meals were served at appropriate intervals throughout the day and in keeping with best practice guidance contained within The Nutritional Guidelines and Menu Checklist for Residential and Nursing Homes.

The registered manager confirmed a choice of hot and cold drinks and a variety of snacks which meet individual dietary requirements and choices were offered midmorning afternoon and at supper times.

The inspector observed that a choice of fluids to include fresh drinking water were available and refreshed regularly. Staff were observed offering patients fluids at regular intervals throughout the day.

Staff spoken with were knowledgeable regarding wound and pressure ulcer prevention, nutritional guidelines, the individual dietary needs and preference of patients and the principles of providing good nutritional care. Four staff consulted could identify patients who required support with eating and drinking.

On the day of the inspection, the inspector observed the lunch meal. Observation confirmed that meals were served promptly and assistance required by patients was delivered in a timely manner.

Staff were observed preparing and seating the patients for their meal in a caring, sensitive and unhurried manner. Staff were also noted assisting patients with their meal and patients were offered a choice of fluids. The tables were well presented with condiments appropriate for the meal served.

Discussion with the registered manager, registered nurses, care staff and review of the staff training records revealed that these staff were trained in wound management and pressure area care and prevention.

Discussion with the registered nurses clearly evidenced their knowledge in the assessment, management and treatment of wounds. Review of the template used to undertake competency and capability assessments for the registered nurses revealed that pressure ulcer/wound care was addressed.

Provider's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**
Inspector's overall assessment of the nursing home's compliance level against the standard assessed	**Substantially compliant**

11.0 Additional Areas Examined

11.1 Documents required to be held in the Nursing Home

Prior to the inspection a checklist of documents required to be held in the home under regulation 19(2) schedule 4 of The Nursing Homes Regulations (Northern Ireland) was forwarded to the home for completion. The evidence provided in the returned questionnaire confirmed that the required documents were maintained in the home and were available for inspection. The inspector reviewed the following records.

- The home's statement of purpose
- The patient's guide
- Sample of reports of unannounced visits to the home under regulation 29
- Record of complaints
- Sample of incidents/accidents records
- Record of food provided for patients
- Sample of the minutes of staff meetings
- Staff training records.

11.2 Patients under guardianship

Information regarding arrangements for any people who were subject to a Guardianship Order in accordance with Articles 18-27 of the Mental Health (Northern Ireland) Order 1986 at the time of the inspection, and living in or using this service was sought as part of this inspection. During the inspection there were no patients in the home who were subject to a guardianship order.

On the day of inspection there were no patients in the home that were subject to a guardianship order.

11.3 Human Rights Act 1998 and European Convention on Human Rights (ECHR)

The inspector discussed the Human Rights Act and the Human Rights Legislation with the registered manager. The inspector can confirm that copies of these documents were available in the home.

11.4 Quality of interaction schedule (QUIS)

The inspector undertook a number of periods of observation in the home which lasted approximately 30 minutes each.
The inspector observed the patients' lunch time meal which was served in the dining room, a small number of patients in the small day room were also observed.
The observation tool used was the quality of interactions between staff, patients, residents and visitors.

The staff were observed seating the patients in preparation for their lunch in an unhurried manner.
The staff explained to the patients their menu choice and provided adequate support and supervision.
Observation of care practices in the day rooms revealed that staff were respectful in their interactions with the patients.

Overall the periods of observations were positive.

Positive interactions	All positive
Basic care interactions	
Neutral interactions	
Negative interactions	

A description of the coding categories of the Quality of Interaction Tool is appended to the report at appendix 2.

11.5 Complaints

Prior to the inspection a complaints questionnaire was forwarded by the Regulation and Quality Improvement Authority (RQIA) to the home for completion. The evidence provided in the returned questionnaire indicated that complaints were managed appropriately.

11.6 Patient Finance Questionnaire

Prior to the inspection a patient questionnaire was forwarded by RQIA to the home for completion. The evidence provided in the returned questionnaire indicated that patients' monies were being managed in accordance with legislation and best practice guidance.

11.7 NMC declaration

Prior to the inspection the manager was asked to complete a proforma to confirm that all nurses employed were registered with the Nursing and Midwifery Council of the United Kingdom (NMC).

The evidence provided in the returned proforma indicated that all nurses, including the manager were registered with the NMC.

11.8 Staffing /Staff Comments

On the day of inspection the inspector examined four weeks duty rosters inspection confirmed that registered nurses and care staff for day and night duty were in accordance with the RQIA's minimum staffing guidelines.

The inspector spoke to 10 staff members during the inspection process five staff completed staff questionnaires.

Examples of staff comments were for as example:

"Yes I have had training in the recording of food and fluid intake charts."
"It's a very friendly nursing home and everyone works to their best ability."
"Everyone works well together and provides the best care possible."
"It's a very welcoming nursing home, all nurses, management, and care assistants always try their best to be accommodating to all of the residents wishes."
"I think each care assistant try's their best to care for individual in the home at all times."
"I find that the care delivered in Cove Manor is of the highest standards and all staff give the best care possible."

“Residents needs are catered for and their independence and dignity are protected.”
“Residents are treated with respect and dignity by all the staff.”
“The staff are all very happy working here and are always pleasant and happy at their work.”

11.9 Patients’/Resident’s Comments/Representatives Comments.

The inspector spoke to five patients and residents individually and with others in groups five patients completed questionnaires.

Examples of their comments were as follows:

“I enjoy the food that I am given in the home.”
“The staff here are very helpful.”
“I always have access to my buzzer.”
“I like living here.”
“I am always offered a choice of food and drink.”

11.10 Representative’s Comments

The inspector spoke to one relative, one relative completed a questionnaire.
Example of the representative’s comments:

“My mother is well cared for and the staff are very friendly and supportive.”

11.11 Environment

The inspector undertook a tour of the home and viewed a number of bedrooms, communal areas and bathroom and toilet facilities.
The premises presented as clean warm and comfortable with a relaxed and friendly ambience. However a number of patients’ bedrooms and residents’ bedrooms doors and architraves required to be refurbished. A requirement is made in this regard.

12.0 Quality Improvement Plan

The details of the Quality Improvement Plan appended to this report were discussed with Mr Sean McCartney Registered Provider and Mrs Madge Quinn Registered Manager.

The timescales for completion commence from the date of inspection.

The registered provider / manager is required to record comments on the Quality Improvement Plan.

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

Enquiries relating to this report should be addressed to:

Heather Moore
The Regulation and Quality Improvement Authority
Hilltop
Tyrone & Fermanagh Hospital
Omagh
BT79 0NS

Appendix One

Section A	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.1 • **At the time of each patient's admission to the home, a nurse carries out and records an initial assessment, using a validated assessment tool, and draws up an agreed plan of care to meet the patient's immediate care needs. Information received from the care management team informs this assessment.** **Criterion 5.2** • **A comprehensive, holistic assessment of the patient's care needs using validated assessment tools is completed within 11 days of admission.** **Criterion 8.1** • **Nutritional screening is carried out with patients on admission, using a validated tool such as the 'Malnutrition Universal Screening Tool (MUST)' or equivalent.** **Criterion 11.1** • **A pressure ulcer risk assessment that includes nutritional, pain and continence assessments combined with clinical judgement is carried out on all patients prior to admission to the home where possible and on admission to the home.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations12(1)and (4);13(1); 15(1) and 19 (1) (a) schedule 3**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Initial assessments are carried out on admission and a care plan is agreed with the patient/relative. The multidisciplanary team would also have input into this process. A comprehensive care plan is completed within 11 days of admission. Nutrional screening is part oEf the initial assessment along with a pressure ulcer risk assessment where appropriate.	Substantially compliant

Section B	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.3 • **A named nurse has responsibility for discussing, planning and agreeing nursing interventions to meet identified assessed needs with individual patients' and their representatives. The nursing care plan clearly demonstrates the promotion of maximum independence and rehabilitation and, where appropriate, takes into account advice and recommendations from relevant health professional.** **Criterion 11.2** • **There are referral arrangements to obtain advice and support from relevant health professionals who have the required expertise in tissue viability.** **Criterion 11.3** • **Where a patient is assessed as 'at risk' of developing pressure ulcers, a documented pressure ulcer prevention and treatment programme that meets the individual's needs and comfort is drawn up and agreed with relevant healthcare professionals.** **Criterion 11.8** • **There are referral arrangements to relevant health professionals who have the required knowledge and expertise to diagnose, treat and care for patients who have lower limb or foot ulceration.** **Criterion 8.3** • **There are referral arrangements for the dietician to assess individual patient's nutritional requirements and draw up a nutritional treatment plan. The nutritional treatment plan is developed taking account of recommendations from relevant health professionals, and these plans are adhered to.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations13 (1);14(1); 15 and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Each resident is assigned a named nurse whose role is to liase with the patient/family when developing an individuals care plan which promotes maximum independence for the resident. Wound prevention/care procedures are implemented where necessary. Referral procedures are n place for access to the tissue viability nurse and the dietician.	Substantially compliant

Section C	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.4 • **Re-assessment is an on-going process that is carried out daily and at identified, agreed time intervals as recorded in nursing care plans.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulations 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Reassessment is continual process.	Substantially compliant

Section D	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.5 • **All nursing interventions, activities and procedures are supported by research evidence and guidelines as defined by professional bodies and national standard setting organisations.** **Criterion 11.4** • **A validated pressure ulcer grading tool is used to screen patients who have skin damage and an appropriate treatment plan implemented.** **Criterion 8.4** • **There are up to date nutritional guidelines that are in use by staff on a daily basis.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 12 (1) and 13(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
All interventions follow supported guidelines. A validated pressure ulcer grading tool and up to date nutritional guidelines are in place.	Substantially compliant

Section E	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.6 • **Contemporaneous nursing records, in accordance with NMC guidelines, are kept of all nursing interventions, activities and procedures that are carried out in relation to each patient. These records include outcomes for patients.** **Criterion 12.11** • **A record is kept of the meals provided in sufficient detail to enable any person inspecting it to judge whether the diet for each patient is satisfactory.** **Criterion 12.12** • **Where a patient's care plan requires, or when a patient is unable, or chooses not to eat a meal, a record is kept of all food and drinks consumed.** **Where a patient is eating excessively, a similar record is kept.** **All such occurrences are discussed with the patient are reported to the nurse in charge. Where necessary, a referral is made to the relevant professionals and a record kept of the action taken.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 19(1) (a) schedule 3 (3) (k) and 25**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nursing records are kept in accordance withh all regulations and nmc guidelines. All meals are recorded.	Substantially compliant

Section F	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.7 • **The outcome of care delivered is monitored and recorded on a day-to-day basis and, in addition, is subject to documented review at agreed time intervals and evaluation, using benchmarks where appropriate, with the involvement of patients and their representatives.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation 13 (1) and 16**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Care outcomes are recorded daily. Care plans are regularly reviewed and this review involves the resident and/or their representative.	Substantially compliant

Section G	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 5.8 • **Patients are encouraged and facilitated to participate in all aspects of reviewing outcomes of care and to attend, or contribute to, formal multidisciplinary review meetings arranged by local HSC Trusts as appropriate.** **Criterion 5.9** • **The results of all reviews and the minutes of review meetings are recorded and, where required, changes are made to the nursing care plan with the agreement of patients and representatives. Patients, and their representatives, are kept informed of progress toward agreed goals.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13 (1) and 17 (1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Changes to care plans are agreed with patients/representatives. Where appropriate patients are encouraged to be acively involved in the creation / reviews of care plans.	Substantially compliant

Section H	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 12.1 • **Patients are provided with a nutritious and varied diet, which meets their individual and recorded dietary needs and preferences.** **Full account is taken of relevant guidance documents, or guidance provided by dieticians and other professionals and disciplines.** **Criterion 12.3** • **The menu either offers patients a choice of meal at each mealtime or, when the menu offers only one option and the patient does not want this, an alternative meal is provided.** **A choice is also offered to those on therapeutic or specific diets.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 12 (1) & (4), 13 (1) and 14(1)**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
A nutritious and varied diet is available. Choices are provided at each mealtime. Guidance documents and dieticians advice are followed.	Substantially compliant

Section I	
Standard 5: Patients receive safe, effective nursing care based on a holistic assessment of their care needs that commences prior to admission to the home and continues following admission. Nursing care is planned and agreed with the patient, is accurately recorded and outcomes of care are regularly reviewed.	
Criterion 8.6 • **Nurses have up to date knowledge and skills in managing feeding techniques for patients who have swallowing difficulties, and in ensuring that instructions drawn up by the speech and language therapist are adhered to.** **Criterion 12.5** • **Meals are provided at conventional times, hot and cold drinks and snacks are available at customary intervals and fresh drinking water is available at all times.** **Criterion 12.10** • **Staff are aware of any matters concerning patients' eating and drinking as detailed in each individual care plan, and there are adequate numbers of staff present when meals are served to ensure:** o **risks when patients are eating and drinking are managed** o **required assistance is provided** o **necessary aids and equipment are available for use.** **Criterion 11.7** • **Where a patient requires wound care, nurses have expertise and skills in wound management that includes the ability to carry out a wound assessment and apply wound care products and dressings.** **Nursing Home Regulations (Northern Ireland) 2005 : Regulation/s 13(1) and 20**	
Provider's assessment of the nursing home's compliance level against the criteria assessed within this section	**Section compliance level**
Nurses are aware of the necessary care for patients with swallowing difficulties. Meals are provided at conventional times . Hot and Cold drinks areavailable at all times. Staff are aware of each patients dietary requirments. Nurses have up to date knowledge of wound prevention and care.	Substantially compliant

PROVIDER'S OVERALL ASSESSMENT OF THE NURSING HOME'S COMPLIANCE LEVEL AGAINST STANDARD 5	COMPLIANCE LEVEL
	Substantially compliant

Appendix 2

Explanation of coding categories as referenced in the Quality of Interaction Schedule (QUIS)

Positive social (PS) – care over and beyond the basic physical care task demonstrating patient centred empathy, support, explanation, socialisation etc.	**Basic Care: (BC) –** basic physical care e.g. bathing or use if toilet etc. with task carried out adequately but without the elements of social psychological support as above. It is the conversation necessary to get the task done.
• Staff actively engage with people e.g. what sort of night did you have, how do you feel this morning etc. (even if the person is unable to respond verbally) • Checking with people to see how they are and if they need anything • Encouragement and comfort during care tasks (moving and handling, walking, bathing etc.) that is more than necessary to carry out a task • Offering choice and actively seeking engagement and participation with patients • Explanations and offering information are tailored to the individual, the language used easy to understand ,and non-verbal used were appropriate • Smiling, laughing together, personal touch and empathy • Offering more food/ asking if finished, going the extra mile • Taking an interest in the older patient as a person, rather than just another admission • Staff treat people with respect addressing older patients and visitors respectfully, providing timely assistance and giving an explanation if unable to do something right away • Staff respect older people's privacy and dignity by speaking quietly with older people about private matters and by not talking about an individual's care in front of others	**Examples include:** Brief verbal explanations and encouragement, but only that the necessary to carry out the task No general conversation

Neutral (N) – brief indifferent interactions not meeting the definitions of other categories.	**Negative (NS) –** communication which is disregarding of the residents' dignity and respect.
Examples include: • Putting plate down without verbal or non-verbal contact • Undirected greeting or comments to the room in general • Makes someone feel ill at ease and uncomfortable • Lacks caring or empathy but not necessarily overtly rude • Completion of care tasks such as checking readings, filling in charts without any verbal or non-verbal contact • Telling someone what is going to happen without offering choice or the opportunity to ask questions • Not showing interest in what the patient or visitor is saying	**Examples include:** • Ignoring, undermining, use of childlike language, talking over an older person during conversations • Being told to wait for attention without explanation or comfort • Told to do something without discussion, explanation or help offered • Being told can't have something without good reason/ explanation • Treating an older person in a childlike or disapproving way • Not allowing an older person to use their abilities or make choices (even if said with 'kindness') • Seeking choice but then ignoring or over ruling it • Being angry with or scolding older patients • Being rude and unfriendly • Bedside hand over not including the patient

References

QUIS originally developed by Dean, Proudfoot and Lindesay (1993). The quality of interactions schedule (QUIS): development, reliability and use in the evaluation of two domus units. *International Journal of Geriatric Psychiatry* Vol *pp 819-826.

QUIS tool guidance adapted from Everybody Matters: Sustaining Dignity in Care. London City University.

Quality Improvement Plan

Announced Primary Inspection

Cove Manor Private Nursing Home

23 April 2014

The areas where the service needs to improve, as identified during this inspection visit, are detailed in the inspection report and Quality Improvement Plan.

The specific actions set out in the Quality Improvement Plan were discussed with Mr Sean McCartney Registered Provider and Mrs Madge Quinn Registered Manager either during or after the inspection visit.

Any matters that require completion within 28 days of the inspection visit have also been set out in separate correspondence to the registered persons.

Registered providers/managers should note that failure to comply with regulations may lead to further enforcement and/or prosecution action as set out in The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

It is the responsibility of the registered provider/manager to ensure that all requirements and recommendations contained within the Quality Improvement Plan 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on the HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and the Nursing Homes Regulations (NI) 2005

No.	Regulation Reference	Requirements	Number of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	16 (1)	The registered person shall ensure that the Speech and Language Therapist's recommendations are recorded in the patient's care plan on eating and drinking. Ref Section B	One	SALT Recommendations will be recorded in the patients care plan.	From the date of this inspection
2	16 (1)	The registered person shall ensure that a care plan on pain management is maintained in the patient's care plan. Ref Section B	One	Completed	From the date of this inspection
3	27 (2) (b)	The registered person shall ensure that the identified doors and architraves are refurbished. Ref Section 11.13 Section11 (Additional Areas Examined)	One	A refurbishment plan of action for doors and architraves is now in place.	Two Months

Recommendations

These recommendations are based on the Nursing Homes Minimum Standards (2008), research or recognised sources. They promote current good practice and if adopted by the registered person may enhance service, quality and delivery.

No.	Minimum Standard Reference	Recommendations	Number Of Times Stated	Details Of Action Taken By Registered Person(S)	Timescale
1	5.3	It is recommended that the pressure relieving equipment in use on patients' and residents' beds and when sitting out of bed be addressed in patients' and residents' care plans on pressure area care and prevention. Ref Section B	One	Completed	One week
2	12.3	It is recommended that the menu planner be reviewed to include choices for snacks for patients and residents on therapeutic diets. Ref Section H	One	On going.	One week

Please complete the following table to demonstrate that this Quality Improvement Plan has been completed by the registered manager and approved by the responsible person / identified responsible person:

Name of Registered Manager Completing Qip	Madge Quinn
Name of Responsible Person / Identified Responsible Person Approving Qip	Sean McCartney

QIP Position Based on Comments from Registered Persons	**Yes**	**Inspector**	**Date**
Response assessed by inspector as acceptable	Yes	Heather Moore	18 June 2014
Further information requested from provider			