The Regulation and Quality Improvement Authority

Inspection Report

10 August 2021

Corkhill Care Centre

Type of service: Nursing Home
Address: 27 Coolmaghery Road, Donaghmore, Dungannon, BT70 3HJ
Telephone number: 028 8776 7362

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Mr Gary George Watt **Registered Person:** Mr Gary George Watt	**Registered Manager:** Mrs Shona McKeown **Date registered:** 4 April 2017
Person in charge at the time of inspection: Mrs Shona McKeown	**Number of registered places:** 37 There shall be a maximum of 10 persons in category NH-DE and maximum of 2 patients in category NH-LD/LD(E).
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. LD – Learning disability. LD(E) – Learning disability – over 65 years. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 35
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 37 patients. The home is divided in two units over two floors. Rambler's Rest provides general nursing care. Angel's Cove provides care for patients with dementia. Patients have access to communal lounges, dining rooms and a garden. There is also an adjacent Residential Care Home; the Registered Manager for this home manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 10 August 2021 from 9.25 am to 5.10 pm. The inspection was undertaken by a care inspector.

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Patients spoke positively about living in Corkhill Care Centre and said they felt very well cared for. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Areas requiring improvement were identified regarding ensuring consistent terminology is used in care records for modified diets and ensuring treatment rooms are kept locked. Two areas for improvement will be stated for the second time regarding audits and the monthly monitoring reports.

RQIA were assured that the delivery of care and service provided was safe, effective, compassionate and that the home was well led. Addressing the areas for improvement will further enhance the quality of care and services in the home.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

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

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires and 'Tell Us' 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 on-line questionnaire.

The daily life within the home and how staff went about their work was observed.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Shona McKeown, Registered Manager, at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we spoke with 14 patients, both individually and in small groups, and ten staff.

Patients said they were “absolutely” and “definitely” well looked after by the staff who were helpful and friendly. Patients said that they enjoyed the food in the home and the activities on offer.

No patients’ relatives were present during the inspection but a record of compliments about the care provided and thank you cards received from relatives was available to review and these were shared with the staff team.

All the staff we spoke to said that they enjoyed working in the home and felt very well supported by the manager.

Following the inspection we received one completed questionnaire from a relative who indicated that they were very satisfied the care provided was safe, effective, compassionate and well led.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 11 February 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 30 **Stated:** First time	The registered person shall ensure that RQIA are appropriately notified of accidents/incidents that occur in the home.	**Met**
	Action taken as confirmed during the inspection: Review of the records of accidents/incidents maintained in the home confirmed that RQIA had been appropriately notified.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 40 **Stated:** First time	The registered person shall ensure that an up to date supervision schedule is maintained with planned and completed dates of supervision recorded.	**Met**
	Action taken as confirmed during the inspection: An up to date supervision schedule had been developed with planned and completed supervision dates recorded.	

Area for improvement 2 **Ref**: Standard 46 **Stated:** First time	The registered person shall ensure that an audit of all bed rail bumpers in use is carried out and that worn bumpers are identified and replaced in a timely manner.	**Met**
	Action taken as confirmed during the inspection: Review of records evidenced that a bed rail bumper audit was completed on a three monthly basis. Bed rail bumpers in use were observed to be in good condition.	
Area for improvement 3 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that all governance audits contain a system to identify deficits, an action plan if improvements required and show evidence of review in order that effective oversight of the care and services provided can be maintained.	**Not met**
	Action taken as confirmed during the inspection: Discussion with the manager confirmed that she was aware of actions required following the audits completed in the home and kept an informal record of deficits which required action. However, the audits reviewed did not include specific action plans therefore the actions required, by whom and when were not clearly recorded and there was no evidence of identified deficits having been resolved. This area for improvement had not been met and will be stated for the second time.	
Area for improvement 4 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that the monthly monitoring reports include the time to and from of the visit, the content of the report should include sufficient information to provide effective oversight of the monitoring of the quality of services provided in the home and the action plan should include a timescale and identify the person responsible for the action.	**Partially met**
	Action taken as confirmed during the inspection: The monthly monitoring reports reviewed included the time to and from of the visit and an oversight of the monitoring of the quality of services provided in the home. However, they did not identify who had completed the visit and the action plans reviewed did not identify	

	the person responsible for completing the action. This area for improvement was partially met and will be stated for the second time.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

There was evidence that a robust system was in place to ensure staff were recruited correctly to protect patients. New staff were provided with an induction programme. There was a system in place to monitor the registration status of nurses with the Nursing and Midwifery Council (NMC) and care staff with the Northern Ireland Social Care Council (NISCC).

There were systems in place to ensure staff were trained and supported to do their job. Staff said that they were provided with a range of mandatory training to enable them to carry out their roles effectively. Review of training records evidenced that mandatory training was provided in an online format but also face to face when required, for example, in fire safety awareness and moving and handling training. A training matrix and record of staffs' compliance was maintained and staff were reminded when training was due.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and identified the person in charge when the manager was not on duty. The manager said that the number of staff on duty was reviewed on at least a monthly basis to ensure that the needs of the patients were met. Agency staff were occasionally required; the manager said efforts were made to book staff who were familiar with the home if the need for agency cover arose.

All the staff we spoke with said that teamwork was very good and that they felt well supported in their role. They were also satisfied with staffing levels and the communication between staff and management. Staff told us that there was enough staff on duty to meet the needs of the patients and observations of the daily routine evidenced that this was the case. Staff were seen to be responsive to the needs of patients and to provide them with choices and options throughout the day.

Staff told us that meeting the needs of the patients was very important to them; they said "you can't rush the patients, we need to go at their pace" and "it's all about the patients here and making sure they are okay". It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

Patients said that all the staff were helpful and friendly and spoke positively about the care they received. They said "the staff are fantastic, couldn't be better" and "oh the staff are great, I am so well looked after". Comments made by patients and staff were brought to the attention of the manager for information.

5.2.2 Care Delivery and Record Keeping

Staff said that they received a handover at the start of each shift to ensure that they were aware of any changes in the needs of the patients. Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Patients' care records were held confidentially.

Staff displayed their knowledge of individual patients' needs and preferences and were seen to be skilled in communicating with patients. Staff were respectful, understanding and sensitive to patients' needs. It was observed that staff respected patients' privacy; they knocked on bedroom and bathroom doors before entering and discreetly offered patients assistance with their personal care needs.

Review of patients' records and discussion with staff confirmed that the correct procedures were followed if restrictive practices and equipment, for example, alarm mats or bed rails, were required. It was established that safe systems were in place to manage this aspect of care.

Patients who are less able to mobilise require special attention to their skin care. Those patients who required assistance to change their position had this clearly recorded in their care records. Care records accurately reflected the patients' needs and repositioning records reviewed were maintained contemporaneously.

Where a patient was at risk of falling, measures to reduce this risk were put in place, for example, aids such as alarm mats, bed rails and crash mats were in use if required. Examination of records and discussion with staff confirmed that in the event of a fall the home's post fall protocol was implemented and the relevant care records were evaluated and updated in the event of a fall.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The dining experience was seen to be an opportunity for patients to socialise, music was playing, and the atmosphere was calm, relaxed and unhurried. Patients were provided with the range of support they required from simple encouragement through to full assistance from staff. Staff were seen to communicate effectively with each other to ensure that the needs of all the patients were met in a timely manner. Patients were offered an opportunity for hand hygiene before and after their meal.

It was observed that patients were enjoying their meal and the dining experience; there was lots of friendly chat during the meal and it was obvious that patients and staff knew each other well. There was a choice of meals on offer and the food was attractively presented and smelled appetising. Staff offered patients a choice of hot and cold drinks during and after the meal. Staff told us how they were made aware of patients' nutritional needs to ensure that patients received the right consistency of diet.

Patients' weights were checked at least monthly to monitor weight loss or gain. Care records contained recommendations from the Dietician and the Speech and Language Therapist (SALT). Contemporaneous records were kept of what patients had to eat and drink daily. However, it was observed that, for those patients on a modified diet, the food intake record was less informative than for patients who ate a normal diet.

Also, in the records reviewed it was observed that the terminology used to describe the modified dietary requirements was not consistent. This was brought to the attention of the manager and an area for improvement was identified.

Review of the wound care records for one patient evidenced that the care plan reflected the recommendations of the Dermatologist regarding the type of dressing to be used. The wound chart was completed up to date. It was observed that the care plan needed to be updated to reflect a change in the frequency of the dressing; this was brought to the attention of the manager who ensured action was taken to update the care plan.

Care records were well maintained and regularly reviewed to ensure they continued to meet the patients' needs. There was clear evidence of consultation with patients and their relatives regarding their care needs. Care plans were detailed and contained specific information on each patients' care needs and what or who was important to them. Patients' individual likes and preferences were reflected throughout the records, for example, preferred clothing to wear, food likes and dislikes and hobbies and interests.

Informative daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from or recommendations made by any healthcare professionals was recorded.

It was apparent that staff assisted patients with all aspects of their personal care needs as required. Patients said that they felt well looked after in the home. Patients spoke very positively about the food on offer and the mealtime experience. They said the food was "delicious" and "very tasty"; one patient asked staff to "give my compliments to the chef".

5.2.3 Management of the Environment and Infection Prevention and Control

The home was observed to be clean, tidy and fresh smelling throughout. Patients' bedrooms were attractively decorated and personalised with items that were important to them such as family photographs, ornaments and scatter cushions. Fire exits and corridors were free from any obstructions.

The Registered Person said that a redecoration and refurbishment plan was in place, routine maintenance checks were carried out and additional improvements were undertaken as required. It was observed that redecoration had been carried out and new furniture and curtains had been fitted to various areas of the home since the previous inspection.

The communal lounges were tastefully decorated and well-appointed with comfortable seating, large TV's, and, newspapers and magazines for patients' to enjoy. The dining rooms were also tastefully decorated, clean and tidy and menus were on display.

It was observed that the treatment rooms were clean, tidy and well organised but both had been left unlocked; the doors were immediately locked and this was brought to the attention of the manager. An area for improvement was made.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases, for example, the home participated in the regional testing arrangements for patients, staff and care partners.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of PPE had been provided. Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

Patients said that the home was always kept clean and tidy; they were complimentary about the environment and one patient remarked that “it’s like a hotel here”.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. It was observed that staff offered patients’ choices regarding, for example, what they would like to eat, where they wanted to sit during the day and if they wanted a lie down in their bedroom after lunch. Patients said that they felt listened to and were confident that if they had a concern it would be sorted out.

A record of patients’ meetings was maintained; these meetings gave patients an opportunity to voice their views on the home and let staff know if they had any requests or concerns.

Patients who chose to sit in the lounges were seen to be comfortable and engaged in each other’s company. Patients in one of the lounges were knitting and chatting, they said “we all get on well and it’s lovely to get together”. Patients who were in their rooms had TV’s or radios on as they preferred and call bells within reach in case they needed to call for assistance.

The activity planner was on display and the activities on offer included, for example, bingo, arts and crafts, ‘brain training’, football, an ‘origins of superstitions’ talk and target games. The manager said that clergy were not yet visiting the home but patients were able to watch Mass and church services online and Songs of Praise on the TV. Patients said there was a birthday celebration nearly every week.

In the afternoon the Activity Therapist engaged the patients in a lively target game, there was a lot of fun and laughs and staff made efforts to ensure patients were able to join in whatever their ability. Patients spoke very positively about the Activity Therapist and the activities on offer; they said they really looked forward to the activities.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff assisted patients to make phone or video calls. Visiting and Care Partner arrangements were in place and managed according to the current Department of Health (DoH) guidance.

There was a warm and welcoming atmosphere throughout the home. Staff were observed to treat the patients with kindness and courtesy; they wished patients a good morning, asked how they were and if they had enjoyed their meal.

Patients were very complimentary about all aspects of life in the home; they said “I absolutely love it here”, “the staff are fantastic, couldn’t be better”, and “the staff are great, I am so well looked after”.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Shona McKeown has been the Registered Manager in this home since 4 April 2017. There was a clear organisational structure in place. Staff demonstrated their understanding of their own roles and responsibilities in the home and of reporting any concerns about patient care or staffs' practices.

There was evidence that a system of auditing was in place across various aspects of care and services provided by the home to monitor the quality of care and other services provided to patients. However, as previously mentioned in section 5.1, the audits reviewed did not include specific action plans therefore the actions required, by whom and when were not evident. There was no evidence of identified deficits having been resolved. This area for improvement had not been met and will be stated for the second time.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

There was evidence that the manager ensured that complaints were managed correctly and that good records were maintained. The manager told us that complaints were seen as an opportunity to for the team to learn and improve.

A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly and reported appropriately.

Staff commented positively about the manager and described her as "approachable and very considerate". They said they could go to the manager about anything and that she "really tries to help".

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports reviewed contained an oversight of the monitoring of the quality of services provided in the home. However, the identity of the person completing the report was not recorded nor had they signed the reports and the action plans did not identify the person responsible for completing the action. This area for improvement was partially met and will be stated for the second time.

6.0 Conclusion

Patients looked well cared for and spoke positively about life in Corkhill Care Centre. Staff were seen to treat patients with kindness and respect and to offer them choices about their care needs and how they would like to spend their day.

The home was clean, tidy and attractively decorated; the environment was pleasant and welcoming for patients, visitors and staff.

Based on the inspection findings two areas for improvement will be stated for the second time; there are in relation to audits and monthly monitoring reports. Two new areas for improvement were identified; these are in relation to ensuring consistent terminology is used regarding modified diets and ensuring treatment room doors are not left unlocked.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with the Care Standards for Nursing Homes (April 2015)

	Regulations	Standards
Total number of Areas for Improvement	0	4*

* The total number of areas for improvement includes two that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Shona McKeown, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 35 **Stated:** Second time **To be completed by:** 10 September 2021	The registered person shall ensure that all governance audits contain a system to identify deficits, an action plan if improvements required and show evidence of review in order that effective oversight of the care and services provided can be maintained. Ref: 5.1 & 5.2.5
	Response by registered person detailing the actions taken: The registered person shall endeavor to ensure that all governance audits being completed will clearly identify deficits and that if an action plan is required evidence is provided to provide assurance that effective care is being provided and maintained.
Area for improvement 2 **Ref:** Standard 35 **Stated:** Second time **To be completed by:** 10 September 2021	The registered person shall ensure that the monthly monitoring reports include the time to and from of the visit, the content of the report should include sufficient information to provide effective oversight of the monitoring of the quality of services provided in the home and the action plan should include a timescale and identify the person responsible for the action. Ref: 5.1 & 5.2.5
	Response by registered person detailing the actions taken: The registered person shall ensure that when the monthly monitoring reports are being completed that they will clearly included the times to and from of the visit. Their content will include sufficient detail to provide assurance that effective monitoring of the quality of the service is being provided in the home. The report will include a timescale for action and clearly identify the person responsible for the action.
Area for improvement 3 **Ref:** Standard 12 **Stated:** First time **To be completed by:** Ongoing from the date of	The registered person shall ensure that the correct modified diet terminology, which is reflective of the recommendations of the SALT, is consistently used in care records relating to patients' nutritional requirements and dietary recommendations. The food intake records for patients on a modified diet should be sufficiently detailed. Ref: 5.2.2

the inspection	**Response by registered person detailing the actions taken:** The registered person shall ensure that staff consistently use in their practice and documentation the correct modified diet terminology which is reflective of the recommendation of the SALT. She will ensure that food intake records are sufficiently detailed to evidence the resident's dietary intake.
Area for improvement 4 **Ref:** Standard 30 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that medicines are safely and securely stored at all times. Treatment rooms should be locked when unattended. Ref: 5.2.3
	Response by registered person detailing the actions taken: **The registered person shall ensure medicines are safely and securely stored at all times and that the keypads in place are used to lock the treatment rooms when unattended.**

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

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