



The **Regulation** and  
**Quality Improvement**  
Authority

# UnannouncedCare Inspection Report 15 October 2019



## Corkhill Care Centre

**Type of Service: Nursing Home**  
**Address: 27 Coolmaghery Road, Donaghmore,**  
**Dungannon, BT70 3HJ**  
**Tel No: 0288776 7362**  
**Inspector: Jule Palmer**

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Assurance, Challenge and Improvement in Health and Social Care

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

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

## 1.0 What we look for



## 2.0 Profile of service

This is a registered nursing home which provides care for up to 36 patients.

### 3.0 Service details

<b>Organisation/Registered Provider:</b> Mr Gary George Watt  <b>Responsible Individual(s):</b> Mr Gary George Watt	<b>Registered Manager and date registered:</b> Mrs Shona McKeown 4 April 2017
<b>Person in charge at the time of inspection:</b> Ann Donnelly- Deputy Manager	<b>Number of registered places:</b> 36  There shall be a maximum of 10 persons in category NH-DE and a maximum of 2 patients in category NH-LD/LD(E).
<b>Categories of care:</b> 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.	<b>Number of patients accommodated in the nursing home on the day of this inspection:</b> 34

### 4.0 Inspection summary

An unannounced care inspection took place on 15 October 2019 from 09.30 hours to 16.55 hours.

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.

Evidence of good practice was found in relation to staffing, recruitment, training, the home's environment, management of nutritional needs, consultation with other healthcare professionals, dignity and privacy, listening to and valuing patients, communication, the culture and ethos in the home, governance arrangements and teamwork.

Areas requiring improvement were identified in relation to having a schedule of supervision dates in place, condition of mattresses in use and falls management.

Patients described living in the home as being a good experience. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surroundings and in their interactions with staff.

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

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

#### 4.1 Inspection outcome

	Regulations	Standards
<b>Total number of areas for improvement</b>	0	3

Details of the Quality Improvement Plan (QIP) were discussed with Ann Donnelly, manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

#### 4.2 Action/enforcement taken following the most recent inspection dated 14 January 2019

The most recent inspection of the home was an unannounced care inspection undertaken on 14 January 2019. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

#### 5.0 How we inspect

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

During our inspection we:

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

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

A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from 7 to 20 October 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- two staff recruitment and induction files
- four patients' care records including food and fluid intake charts and repositioning charts
- a sample of governance audits/records
- nurse competency and capability assessment records
- complaints and compliments record
- a sample of monthly quality monitoring reports from January 2019
- RQIA registration certificate

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

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

## 6.0 The inspection

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 35  <b>Stated:</b> First time	The registered person shall ensure that robust environmental audits are maintained to quality assure the standard of hygiene in the home by: <ul style="list-style-type: none"> <li>• ensuring that necessary equipment is available for staff to reduce the risk and spread of infection</li> <li>• replacing or repairing damaged equipment as identified in 6.4.</li> </ul>	<b>Met</b>
	<b>Action taken as confirmed during the inspection:</b> Review of equipment and the environment evidenced that the required improvements had been made. Review of environmental audits evidenced that these had been robustly completed.	

No areas for improvement were identified at the previous medicines management on 22 May 2018.

## 6.2 Inspection findings

### 6.3 Is care safe?

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

We discussed the planned daily staffing levels for the home with the manager who confirmed that these were subject to at least monthly review to ensure the assessed needs of patients were met. The duty rotas reviewed reflected that the planned daily staffing levels were adhered to. Staff spoken with were very satisfied with staffing levels.

We also sought staff opinion on staffing via the online survey; no responses were received. Patients spoken with told us that they were satisfied with staffing levels, comments included:

- “The staff are great.”
- “The nurses and all the staff are great.”
- “The home is busy and staff try their best.”

Patients’ relatives spoken with also indicated that they were satisfied with staffing levels and the care provided; comments included:

- “Everything is 100 per cent, they are great here.”
- “Staff are fantastic.”
- “Staff are excellent.”

We also sought the opinion of patients and patients’ visitors on staffing levels via questionnaires; one response was received from a patient who indicated they were satisfied with staffing levels.

We reviewed two staff recruitment and induction files and these evidenced that staff had been vetted prior to commencing employment to ensure they were suitable to work with patients in the home. All staff spoken with stated they had completed, or were in the process of completing, a period of induction and review of records confirmed this.

Discussion with staff and review of records evidenced that staff supervision, appraisals and nurse competency and capability assessments were carried out. However, there was no supervision schedule in place; an area for improvement was made.

We reviewed the system in place to monitor the registration status of registered nurses with the NMC and care staff with NISCC and this clearly identified the registration status of all staff.

Staff spoken with demonstrated their knowledge of how to deal with a safeguarding issue; they were also aware of their duty to report concerns.



Review of care records evidenced that a range of validated risk assessments was completed and informed the care planning process for patients. Where practices were in use that could potentially restrict a patient’s choice and control, for example, bedrails or lap belts, the appropriate risk assessments and care plans had been completed. We observed that care plans for the use of lap belts included a rationale for use and recommendations as to how frequently the lap belt should be released when in use.

We reviewed the home’s environment and entered a selection of bedrooms, bathrooms, shower rooms, storage rooms, sluices, dining rooms and lounges. The home was found to be warm, well decorated, clean and fresh smelling throughout. Patient’s bedrooms were personalised with items that were meaningful to them. Fire exits and corridors were observed to be clear of clutter and obstruction. The responsible individual, who was present during the inspection, informed us that new heating and call bell systems had been installed since the last inspection and a redecoration plan was in place.

Review of a random selection of mattresses evidenced that some required replacement due to worn covers and/or foam. One mattress was replaced during the inspection. A robust system should be in place to monitor the condition of mattresses in use in the home and to ensure these were replaced as necessary; an area for improvement was made.

Staff were observed to wear personal protective equipment (PPE), for example aprons and gloves, when required and PPE was readily available throughout the home.

The manager confirmed that staff compliance with mandatory training was monitored and they were prompted when training was due. Staff spoken with were satisfied they had sufficient access to training; one staff member told us that “the training is great”.

**Areas of good practice**

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, adult safeguarding, risk management and the home’s environment.

**Areas for improvement**

Areas for improvement were identified in relation to ensuring there is supervisionschedule in place and monitoring the condition of mattresses in use.

	Regulations	Standards
<b>Total numb of areas for improvement</b>	0	2

**6.4 Is care effective?**

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

We observed the daily routine and the care given to patients in the home and were satisfied that patients received the right care at the right time. Patients who were unable to express their views appeared to be comfortable and content in their surroundings and in their dealings with staff. Patients who were able to voice their opinions told us that they were very satisfied with the care they received.

Staff spoken with were knowledgeable about the patients' care needs and confirmed that these were regularly reviewed to determine the effectiveness of care delivered and if the patients' needs had changed.

We reviewed the care records for four patients and evidenced that a range of validated risk assessments had been completed to inform care planning for the individual patients.

Patients weights were monitored on at least a monthly basis and their nutritional needs had been identified. There was evidence of referrals having been made to relevant health care professionals, such as the dietician or speech and language therapist (SALT), where necessary. Patients care plans included recommendations from the dietician and/or SALT if required and were regularly reviewed.

We spoke to a dietician who was in the home carrying out dietetic reviews. The dietician commended staff on their management of patients' nutritional needs and told us that they were very responsive to ensuring that dietary recommendations, for example, fortification of food, were put into place. It was noted that several patients had achieved and maintained their target weights and were able to be weaned off dietary supplements.

A monthly falls analysis was completed to determine if there were any trends or patterns emerging and an action plan was devised if necessary. Staff were knowledgeable regarding the actions to take to help prevent falls and how to manage a patient who had a fall. However, review of care records evidenced that neurological observations were not always completed for the full 24 hour period following a fall. Also, the relevant risk assessments and care plans were not reviewed in a consistent manner in the event of a fall. An area for improvement was made.

Risk assessments and care plans were in place to direct care for the prevention of pressure ulceration. Review of settings on pressure relieving mattresses evidenced that identified mattresses were not set at the recommended setting for the weight of the individual patient. Staff stated that none of the patients had any pressure damage and that mattress settings were regularly checked. We discussed the system in place to monitor settings on mattresses with the manager who confirmed that this would be reviewed going forward to ensure it was robust.

We observed the serving of lunch in the ground floor dining room. The menu was on display and a selection of condiments and drinks were available. The food smelled appetising and was well presented. Staff demonstrated their knowledge of how to thicken fluids if necessary and which patients required a modified diet. It was obvious that staff knew the patients well and were aware of their likes and dislikes. Patients were offered clothing protectors. Staff wore aprons and helpfully assisted patients as required. A nurse was overseeing the meal and the atmosphere was calm, unhurried and relaxed. Patients spoken with after lunch told us that they had enjoyed their meal and one commented that "you couldn't beat the food". Food and fluid intake charts were maintained where necessary and the records reviewed were up to date.

We reviewed the care record for a patient who had a wound; this evidenced that a relevant care plan was in place. There had been consultation with the tissue viability nurse, dressings were changed as recommended in the care plan and wound care recording was up to date.



**Areas of good practice**

There were examples of good practice found throughout the inspection in relation to record keeping, management of nutritional needs, consultation with other healthcare professionals, the meal time experience and wound care.

**Areas for improvement**

Areas for improvement were identified in relation to falls management.

	Regulations	Standards
<b>Total number of areas for improvement</b>	0	1

**6.5 Is care compassionate?**

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

We arrived in the home at 09.30 hours and were met by staff who were friendly and welcoming. We observed daily life in the home and noted that staff displayed a consistently caring and comforting approach to the patients in their care.

During the inspection we spoke with 14 patients both individually and in small groups. Patients spoke positively about living in Corkhill; comments included:

- “The place is first class.”
- “It’s nice here.”
- “They look after us the very best.”
- “I am so appreciative of the care I receive.”

Patients’ visitors’ spoken with were also complimentary about the home; they told us:

- “It’s very homely and the staff are very nice.”
- “It’s absolutely out of this world.”

Observation of care delivery evidenced that staff treated patients with dignity and respect. We observed that staff knocked on bedroom and bathroom doors before entering and ensured doors were closed when delivering care to preserve patients’ privacy. We also observed that staff spoke kindly to patients and were responsive to their needs.

The weekly activities were displayed on a notice board in the entrance hall. These included, for example, Christian fellowship, ‘everybody active’, recreational music, hairdressing and a movie. A Harvest Service took place on the day of the inspection to which all patients and visitors were invited. Patients’ spiritual needs were met with the provision of Holy Communion and scheduled Sunday services. Patients’ birthdays were celebrated and a Halloween party was being organised. Patients told us that they enjoyed the activities on offer and felt that they were appropriate.

A record of compliments was maintained and thank you cards were on display; comments included:

- “A big thank you to all the staff in Corkhill for looking after ... so well.”
- “You were all very kind to him, myself and the family.”
- “Thank you for all your care.”
- “Your staff are a credit to Corkhill.”

We were provided with a copy of the annual quality report, completed in November 2018, following the inspection. The manager informed us that consultation with patients and their relatives was underway for inclusion in the 2019 report.

Patients told us that they felt listened to by staff in the home. Patients’ visitors told us that communication and consultation was very good.

Staff were observed to effectively communicate with patients and demonstrated their knowledge of how to communicate with those patients who had difficulties in this area.

### Areas of good practice

There were examples of good practice found throughout the inspection in relation to treating patients with dignity and privacy, listening to and valuing patients, taking account of the views of patients, the culture and ethos in the home and communication.

### Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
<b>Total number of areas for improvement</b>	0	0

#### 6.6 Is the service well led?

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

The certificate of registration issued by RQIA was displayed in the entrance hall of the home. Discussions with staff and observations confirmed that the home was operating within the categories of care registered.

There had been no change in management arrangements since the last inspection. A review of the duty rota evidenced that the manager’s hours and the capacity in which these were worked were clearly recorded.

Discussion with staff, patients and visitors confirmed that the responsible individual, the manager and the deputy manager were all accessible and approachable.

Staff were knowledgeable regarding their own roles and responsibilities; they spoke positively about teamwork and took pride in their work; they also told us that they felt well supported, comments included:

- “Shona is excellent.”
- “I love it here.”
- “We all help each other out.”
- “The patients are genuinely well cared for.”
- “I really enjoy my work.”

It was highlighted that staff meetings should be held quarterly and not bi-annually. This was discussed with the responsible individual who agreed that going forward meetings would be held on a quarterly basis. The responsible individual told us that these meetings provided a formal opportunity to let staff know that they were valued and appreciated.

Systems were in place to monitor and evaluate the quality of nursing care and other services provided in the home and to ensure action was taken as a result of any deficits identified to drive quality improvement. Audits were completed to review areas such as accidents/incidents, patients’ weights, restrictive practices and wounds. Monthly monitoring reports reviewed included a timescale for completion of the identified action plan.

There was a system in place to ensure notifiable events were investigated and reported to RQIA or other relevant bodies appropriately.

Review of the complaints record evidenced that systems were in place to ensure complaints were appropriately managed.

**Areas of good practice**

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

**Areas for improvement**

No areas for improvement were identified during the inspection.

	<b>Regulations</b>	<b>Standards</b>
<b>Total number of areas for improvement</b>	0	0

**7.0 Quality improvement plan**

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Ann Donnelly, Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

### **7.1 Areas for improvement**

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

### **7.2 Actions to be taken by the service**

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

<b>Quality Improvement Plan</b>	
<b>Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015</b>	
<b>Area for improvement 1</b>  <b>Ref:</b> Standard 40  <b>Stated:</b> First time  <b>To be completed by:</b> 15 November 2019	<p>The registered person shall ensure that there is a supervision schedule in place.</p> <p>Ref: 6.3</p> <hr/> <p><b>Response by registered person detailing the actions taken:</b>            A staff supervision schedule has been formatted to ensure adherence as per home policy.</p>
<b>Area for improvement 2</b>  <b>Ref:</b> Standard 46  <b>Stated:</b> First time  <b>To be completed by:</b> 15 November 2019	<p>The registered person shall ensure that there is a robust system in place to monitor the condition of mattresses in use in the home and that these are replaced as necessary.</p> <p>Ref: 6.3</p> <hr/> <p><b>Response by registered person detailing the actions taken:</b>            A three monthly check of the condition of each mattress will be performed and recorded. Replacement mattresses will be purchased as required.</p>
<b>Area for improvement 3</b>  <b>Ref:</b> Standard 22  <b>Stated:</b> First time  <b>To be completed by:</b> With immediate effect	<p>The registered person shall ensure that neurological observations are completed for 24 hours following a fall and that the relevant risk assessments and care plans are consistently updated in the event of a fall.</p> <p>Ref: 6.4</p> <hr/> <p><b>Response by registered person detailing the actions taken:</b>            The registered person will ensure all staff are aware that neurological observations are completed for 24 hours following a fall and that the relevant risk assessment and care plans are updated following a fall. Both my deputy and myself will monitor to ensure adherence.</p>

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



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