Inspection Report

16 September 2022

Three Rivers Care Centre

Type of service: Nursing Home
Address: 11 Millbank Lane, Lisnamallard, Omagh, BT79 7YD
Telephone number: 028 8225 8227

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: Zest Investment (Omagh) Limited **Responsible Individual:** Mr Philip Scott	**Registered Manager:** Ms Jillian Claire McKenna - not registered
Person in charge at the time of inspection: Mrs Bernie McDaniel, Trainee Manager	**Number of registered places:** 56 A maximum of 28 patients in category NH-DE accommodated in the Strule Unit, a maximum of 28 patients in category NH-I and a maximum of 4 patients in category NH-PH accommodated in the Drumragh Unit.
Categories of care: Nursing Home (NH) PH – Physical disability other than sensory impairment. DE – Dementia. I – Old age not falling within any other category.	**Number of patients accommodated in the nursing home on the day of this inspection:** 43
Brief description of the accommodation/how the service operates: This is a registered Nursing Home which provides nursing care for up to 56 patients. The home is divided into two units; Strule unit which provides dementia nursing care on the ground floor and Drumragh unit on the first floor which provides nursing care for all other categories of care listed above. Patient bedrooms and living areas are located over two floors and all bedrooms are single occupancy with an en-suite. Patients have access to communal lounges, dining areas and an outdoor space.	

2.0 Inspection summary

An unannounced inspection took place on 16 September 2022, from 9am to 6pm 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.

Areas for improvement identified during the inspection are detailed throughout this report and within the Quality Improvement Plan (QIP) in section 6.0. Three areas for improvement have been stated for a second time in relation to pressure area care, infection prevention and control (IPC) and risk management. One area for improvement has been escalated from a care standard to a regulation in relation to Speech and Language Therapist (SALT) recommendations.

Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients and staff are included in the main body of this report.

The findings of this report will provide the management team 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 patients and staff were asked for their opinion on the quality of the care and their experience of living or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the 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 findings of the inspection were provided to the Manager at the conclusion of the inspection.

4.0 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "(The) staff are all very good", "Very happy here", "I feel safe here", "(I have) no issues or concerns" and "Very well cared for". There were no questionnaires returned from patients or relatives.

Staff said that the Manager was very approachable, teamwork was great and that they felt well supported in their role. One staff member said: "Very good staff morale" and a further staff member said "I love it here". There was no feedback from the staff online survey.

Comments from patients and staff were shared with the Manager.

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 21 October 2021.		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 14 (2) (a) **Stated:** First time	The registered person shall ensure as far as reasonably practicable that all parts of the home which patients have access are free from hazards to their safety.	**Not met**
	Action taken as confirmed during the inspection: Observation of the environment and discussion with the manager evidenced that this area for improvement had not been met and has been stated for a second time. This is discussed further in section 5.2.3.	
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time	The registered person shall ensure that IPC deficits identified during the inspection are addressed.	**Partially met**
	Action taken as confirmed during the inspection: Observation of the environment and staff practices evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.3.	
Area for improvement 3 **Ref:** Regulation 29	The registered person shall ensure that monthly monitoring visits are completed and a copy of the report forwarded to RQIA following each visit until further notice.	**Met**

Stated: First time	**Action taken as confirmed during the inspection**: Review of relevant governance records and discussion with the manager evidenced that this area for improvement had been met.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 12 **Stated:** Second time	The registered person shall ensure that all relevant staff are knowledgeable regarding patients dietary needs as per SALT recommendations and daily fluid intake charts contain the correct fluid type as per SALT.	**Partially Met**
	Action taken as confirmed during the inspection: Review of relevant care records and discussion with staff evidenced that this area for improvement had not been fully met and has been subsumed into a regulation. This is discussed further in section 5.2.2.	
Area for improvement 2 **Ref:** Standard 23 **Stated:** First time	The registered person shall ensure that where a patient has been assessed as requiring repositioning: • the care plan contains the recommended frequency of repositioning and any specialised equipment • repositioning charts accurately reflect the frequency of repositioning as directed within the care plan • pressure reducing equipment is set according to the manufactures instructions and as detailed within the care plan • an assessment specific to the risk of skin damage is completed on a monthly basis or more frequently as required.	**Partially Met**
	Action taken as confirmed during the inspection: Review of relevant care records and discussion with the manager evidenced that this area for improvement had not been fully met and has been stated for a second time. This is discussed further in section 5.2.2.	

Area for improvement 3 **Ref:** Standard 12 **Stated:** First time	The registered person shall ensure that the provision of meals is safe and effective. With specific reference to ensuring: • that meals are covered on transportation • patients are alert and positioned correctly • food is not left unattended with patients who require assistance and/or supervision with eating.	**Met**
	Action taken as confirmed during the inspection: Observation of the provision of meals and discussion with the manager evidenced that this area for improvement had been met.	
Area for improvement 4 **Ref:** Standard 12.4 **Stated:** First time	The registered person shall ensure that nutritional screening is completed on a monthly basis using a validated assessment tool, or more frequently depending on individual assessed need. The date that the patient is weighed must be recorded within relevant monitoring/assessment charts.	**Met**
	Action taken as confirmed during the inspection: Review of relevant care records and discussion with the manager evidenced that this area for improvement had been met.	
Area for improvement 5 **Ref:** Standard 18 **Stated:** First time	The registered person shall ensure that care plans for the management of distressed reactions contain sufficient detail to direct the required care.	**Met**
	Action taken as confirmed during the inspection: Review of relevant care records and discussion with the manager evidenced that this area for improvement had been met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics including fire safety and adult safeguarding. Staff confirmed that they were provided with relevant training to enable them to carry out their roles and responsibilities effectively.

Appropriate checks had been made to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC) and care workers with the Northern Ireland Social Care Council (NISCC) with a record maintained by the Manager of any registrations pending.

Review of three employees' recruitment records evidenced that not all relevant pre-employment information had been obtained prior to commencing employment. Details were discussed with the management of the home and an area for improvement was identified. Following the inspection written assurances were required from the Responsible Individual in relation to the immediate action taken to address pre- employment recruitment checks. This confirmation was received on 28 September 2022.

Staff said they felt supported in their roles and that there was good team work with effective communication between staff and management. Staff also said that, whilst they were kept busy, the number of staff on duty was generally satisfactory to meet the needs of the patients.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and clearly identified the person in charge when the Manager was not on duty.

The inspector requested a sample of registered nurses competency and capability assessments for taking charge of the home in the absence of the Manager and found these to have been completed.

A matrix system was in place for staff appraisals with the name of the staff member and the date that the appraisal had taken place. However, there was no matrix system for staff supervisions. This was discussed with the Manager who provided evidence that staff supervisions were being completed and agreed to implement a matrix system for supervisions following the inspection.

5.2.2 Care Delivery and Record Keeping

There was clear evidence of a relaxed, pleasant and friendly atmosphere between patients and staff. The inspector also observed where staff facilitated patients' favourite music or television programme for those who were on bed rest.

Patients who were less able to mobilise require special attention to their skin care. Review of three patient's care records relating to pressure area care evidenced that patients were being repositioned as per care plan. However, the type of pressure relieving mattress and specialised equipment was not accurately recorded within two patient's records to direct the relevant care.

It was further identified that an assessment specific to the risk of skin damage had not been updated for two patients. This was discussed in detail with the Manager and an area for improvement has been stated for a second time.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The lunchtime dining experience was seen to be a pleasant opportunity for patients to socialise and the atmosphere was calm and relaxed. Patients who choose to have their lunch in their bedroom had trays delivered to them and the food was covered on transport.

Staff had made an effort to ensure patients were comfortably seated and enjoyed their meal. There was evidence that patients' needs in relation to nutrition and the dining experience were being met. For example, staff recognised that patients may need a range of support with meals and were seen to helpfully encourage and assist patients as required.

There was a choice of meals offered, the food was attractively presented and smelled appetising. Staff knew which patients preferred a smaller portion and demonstrated their knowledge of individual patient's likes and dislikes.

Staff told us how they were made aware of patients' nutritional needs to ensure that recommendations made by Speech and Language Therapist (SALT) were adhered to. Discussion with several staff evidenced that not all staff were familiar with the International Dysphagia Diet Standardisation Initiative (IDDSI) terminology but said they were made aware of patients' nutritional needs to ensure that recommendations made by SALT were adhered to for example; pureed, soft and bite sized.

Whilst discussion with staff evidenced that they were providing the correct diet as recommended by SALT, a number of staff provided inaccurate information regarding identified patient's fluid consistency. Further review of a number of patients' fluid charts evidenced that the recommended fluid consistency as per SALT was either incorrectly recorded or not recorded within all charts to direct relevant care. As mentioned above in section 5.1 this has been subsumed into an area for improvement under regulation.

The inspector observed that patients' confidential information was not held securely in two areas of the home and there was potential for unauthorised access. The potential breach of confidentiality was discussed with the Manager and an area for improvement was identified.

Care records were mostly well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. A small number of deficits were identified, for example; scoring out resulting in the original entry not being able to be read and not all care records were signed/dated by the staff member who made the entry. Details were discussed with the Manager who agreed to discuss with relevant staff and to monitor going forward.

A record of patient property for three patients evidenced that these had not been signed/dated by two staff. Discussion with the management team further identified that an inventory of patient property was not being reviewed on a quarterly basis. Details were discussed with the management team and an area for improvement was identified.

5.2.3 Management of the Environment and Infection Prevention and Control

Observation of the home's environment included reviewing a sample of bedrooms, bathrooms, storage spaces and communal areas such as lounges. Corridors were clear of clutter and obstruction and fire exits were also maintained clear.

The home was warm, clean and comfortable. Patients' bedrooms were personalised with items important to the patient. The Manager confirmed that an audit of the environment is completed on a monthly basis and an action plan implemented where deficits are identified to ensure the home is well maintained.

A number of unnecessary risks were identified which had the potential to impact on the health and safety of patients. For example; a store within the dementia unit was unlocked with access to a staff handbag; the kitchenette on the first floor was unlocked with access to food thickening agents, staff handbags and cleaning chemicals. The importance of ensuring that all areas of the home are hazard free was discussed with the Manager and an area for improvement has been stated for a second time.

The Manager told us that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases and that any outbreak of infection was reported to the Public Health Agency (PHA).

There was a good supply of PPE and hand sanitising gel in the home. Staff use of PPE and hand hygiene was regularly monitored by management and records were kept. The Manager also said that any issues observed regarding IPC measures or the use of PPE was immediately addressed.

Observation of staff practices evidenced that they were not consistently adhering to IPC measures, including the appropriate wearing of face masks, donning and doffing of personal protective equipment (PPE) and hand hygiene. It was further identified that a small number of patient equipment was inappropriately stored within a number of communal bathrooms some of which required a thorough cleaning. Details were discussed with the Manager who acknowledged that these findings were not in keeping with IPC best practice and an area for improvement has been stated for a second time.

5.2.4 Quality of Life for Patients

Observation and discussion with staff confirmed that patients were able to choose how they spent their day. For example, patients could go outside, remain in their bedroom or go to a communal room when they requested.

During the inspection patients were observed engaged in their own activities such as; watching TV, sitting in the lounge resting or chatting to staff. Patients appeared to be content and settled in their surroundings and in their interactions with staff.

Patients commented positively about the food provided within the home with comments such as; "(The) food is very good" and "(The) food is very nice".

Observation of life in the home and discussion with staff and patients established that staff engaged with patients individually or in groups; patients were afforded the choice and opportunity to engage in social activities, if they wished.

5.2.5 Management and Governance Arrangements

There has been no change to management arrangements for the home since the last inspection. The Manager said they felt well supported by senior management and the organisation.

There was evidence that the Manager had a system of auditing in place to monitor the quality of care and other services provided to patients. Where deficits were identified the audit process included an action plan with the person responsible for completing the action, a time frame for completion and a follow up to ensure the necessary improvements had been made.

The home was visited each month by a representative of the Responsible Individual to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed and available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

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

	Regulations	Standards
Total number of Areas for Improvement	4*	3*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Bernie McDaniel, Trainee 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 Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) (a) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure as far as reasonably practicable that all parts of the home which patients have access are free from hazards to their safety. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: Both the unlocked servery door in the General nursing unit and the unlocked store in the Dementia unit which contained a staff handbag were addressed immediately on the day of inspection. Notices are already in place to advise staff of this. A further instant Whatsapp communication reminder was also issued. The matter was further addressed during the Nurses meeting 28.09.22, Carers meeting 12.10.22 and ongoing via Manager's attendance at handovers were all staff have again been told of the importance of safety and that all serverys, linen cupboards, stores, sluice areas and clinical rooms must be kept locked at all times. Staff personal belongings are not permitted on the units and lockers are provided in the staff room. CCTV reviewers are also aware of this and will send footage and reports of any identified safety issues.
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** Second time **To be completed by:** With immediate effect	The registered person shall ensure that IPC deficits identified during the inspection are addressed. Ref: 5.1 and 5.2.3
	Response by registered person detailing the actions taken: Identified equipment was removed from communal areas and thoroughly cleaned immediately on the day of inspection. Findings of the inspection in relation to IPC deficits were discussed with staff via Manager's attendance at handovers and staff meetings. Relevant Hand hygiene, COSHH and Infection controul audits continue to be completed monthly and more if necessary with deficits identified corrected immediately and action plans implemented. Whatsapp communication reminders are ongoing. Staff are aware that if they continue to breach uniform policy in relation to nail polish/extensions and jewellry they will be excused from duty immediately (staffing permitting) and proceed to disciplinary action. CCTV reviewers are also aware of this and will send footage and reports of any identified safety issues.

Area for improvement 3 **Ref:** Regulation 21 (1) (a) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all persons are recruited in accordance with best practice and legislation and that the efficacy of this is present in staff recruitment and selection files prior to commencing employment. Ref: 5.2.1
	Response by registered person detailing the actions taken: The recruitment files referred to were those of overseas staff who came to Three Rivers initially or following internal transfer from our Birmingham sites. In the case of the staff employed initially, Three Rivers had to apply for AccessNI checks after their start date as it transpired this was not completed by the supplying agent. In the case of internally transferred applicants AccessNI checks were not competed as the employees already had satifactory DBS checks in place. As per assurances sent to RQIA all staff have satisfactory AccessNI checks in place, any future internally transferred staff will have an AccessNI check completed routinely and following personnel audit any recruitment files with deficit areas have been addressed.
Area for improvement 4 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall review the management of patients' nutritional care needs to ensure that : • SALT recommendations are consistently and accurately recorded within the patients' care records and supplementary recording charts • relevant staff are aware of patients' dietary needs as per SALT and IDDSI terminology. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: All Fluid charts were reviewed and amended/completed as necessary to reflect current SALT recommendations held. Diet/fluid type quick reference charts with IDDSI terms are updated following receipt of SALT assessments or arrival of new admissions and are available in the servery for essy access for staff to check correct consistencies. Nurses are also directed to ensure care plans, fluid and diet notification charts are updated/implemented accordingly. Menu choice sheets have also now been updated to reflect IDDSI terms and alert kitchen to consistencies needed. Dysphagia and IDDSI terminology training took place on 20.09.22 and 06.10.22 as planned prior to this inspection. An instant Whatsapp communication reminder was sent to all staff and a subsequent reminder link for downloading the IDDSI app.

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 23 **Stated:** Second time **To be completed by:** 16 October 2022	The registered person shall ensure that where a patient has been assessed as requiring repositioning: • the care plan contains the recommended frequency of repositioning and any specialised equipment • pressure reducing equipment is set according to the manufactures instructions and as detailed within the care plan • an assessment specific to the risk of skin damage is completed on a monthly basis or more frequently as required. Ref: 5.1 and 5.2.2
	Response by registered person detailing the actions taken: Overdue Braden risk assessments were updated immediately. The identified careplans were updated to reflect the correct mattress type in use and hoist type/sling sizes. Completion of Braden risk assessments, associated care plans and repositioning records have been discussed in full with Nurses. Care file audits and Pressure audits are ongoing routinely to identify deficits and address same.
Area for improvement 2 **Ref:** Standard 37 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that any record retained in the home which details patient information is stored safely in accordance with the General Data Protection Regulation and best practice standards. Ref: 5.2.2
	Response by registered person detailing the actions taken: Storage cabinets within the Nurses's stations have been fitted with locks. Nurses have been advised that in addition to the Clinical room, the Nurse's station door must be locked at all times when not in use. CCTV reviewers are also aware of this and will send footage and reports of any identified safety issues.

Area for improvement 3 **Ref:** Standard 14.26 **Stated:** First time **To be completed by:** 16 October 2022	The registered person shall ensure that an inventory of property belonging to each patient is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff. Ref: 5.2.2
	Response by registered person detailing the actions taken: Inventory recording was discussed at both staff meetings with reminders that same should be signed by 2 staff, preferrably 1 of a higher grade e.g. Care assistant and Nurse.

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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