Announced Care Inspection Report
18 & 23 June 2020

Three Rivers Care Centre

Type of Service: Nursing Home (NH)
Address: 11 Millbank Lane, Lisnamallard, Omagh BT79 7YD
Tel No: 028 8225 8227
Inspectors: Jane Laird and Helen Daly

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 56 patients. The home is divided into two units as detailed in section 3.0 of this report.

3.0 Service details

Organisation/Registered Provider: Zest Care Homes Ltd **Responsible Individual:** Philip Scott	**Registered Manager and date registered:** Charlene Parkin – 18 July 2019
Person in charge at the time of inspection: Charlene Parkin	**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) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** Strule unit - 18 Drumragh unit - 17

4.0 Inspection summary

An announced inspection took place on 18 June 2020 from 10.10 to 19.30 hours. Short notice of the inspection was provided to the manager on the day in order to ensure that arrangements could be made to safely facilitate the inspection.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DoH) directed RQIA to continue to respond to ongoing areas of risk identified in homes. In response to this, RQIA decided to undertake an inspection to this home.

The pharmacy inspector completed a remote inspection to validate the areas for improvement identified at the last medicines management inspection.

The following areas were examined during the inspection:

- staffing
- care delivery
- communication
- care records
- adult safeguarding
- infection prevention and control (IPC) measures
- environment

- management of medicines
- leadership and management arrangements

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

4.0 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	*5	*3

*The total number of areas for improvement includes one under regulation which has been stated for a second time and one under the standards which has been carried forward for review at the next care inspection.

Details of the Quality Improvement Plan (QIP) were discussed with Charlene Parkin, 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.

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 including finance and pharmacy, registration information, and any other written or verbal information received.

This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report

Questionnaires and 'Tell us' 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.

The following records were examined during the inspection:

- staff duty rota for weeks commencing 8 June 2020 and the 15 June 2020
- four patients' daily reports, care records and supplementary charts
- four patients' care charts including food and fluid intake charts and repositioning charts
- adult safeguarding folder
- complaints ledger
- incident and accident records
- record of the manager's daily walk around

- a sample of governance audits/records/action plans
- one staff recruitment file
- monthly monitoring reports from February 2020
- a sample of care plans and associated records relating to medicines management
- two patients' signed written agreements

Areas for improvement identified at the last inspection were reviewed and assessment of compliance recorded as met, not met, or carried forward to the next care inspection.

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

6.0 The inspection

6.1 Review of areas for improvement from previous inspection(s)

The most recent inspection of the home was an unannounced care inspection undertaken on 12 December 2019.

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 13 (4) **Stated:** Second time	The registered manager shall ensure that written confirmation of current medication regimens is obtained for all admissions/re-admissions to the home	**Met**
	Action taken as confirmed during the inspection: A review of the management of medicines for three patients who were recently admitted/re-admitted to the home indicated that hospital discharge letters were received. The personal medication records were verified and signed by two registered nurses to ensure accuracy.	
Area for improvement 2 **Ref**: Regulation 13 (4) **Stated:** Second time	The registered manager shall ensure that medicine refrigerator temperatures are maintained between 2^{o}C - 8^{o}C to ensure that medicines are stored at the manufacturers' recommended temperature.	**Met**

	Action taken as confirmed during the inspection: A review of the daily records indicated that the temperatures were within the required range on most days. Guidance was available to direct staff on the action to take if/when temperatures outside the accepted range were observed.	
Area for improvement 3 **Ref**: Regulation 5 (1) **Stated:** Second time	The registered person shall ensure that any service user currently accommodated in the home that does not have an individual written agreement is provided with one. A full copy of the signed agreement should be retained on the service user's file. Where an HSC trust-managed service user does not have an identified person to act as their representative, the service user's individual agreement should be shared with their HSC trust care manager. Agreements must be kept up to date with any changes agreed in writing by the service user or their representative.	**Met**
	Action taken as confirmed during the inspection: Review of two patients' written agreements evidenced that they had been kept up to date with any changes which were agreed in writing and signed by the patient.	
Area for improvement 4 **Ref**: Regulation 12(b) **Stated:** First time	The registered person shall implement a system to ensure that records show the current balance of patients' monies held within the home at any time.	**Not met**
	Action taken as confirmed during the inspection: On discussion with staff it was evident that a system to ensure that records show the current balance of patients' monies held within the home at any time had not been implemented. This area for improvement has not been met and is stated for a second time.	

Area for improvement 5 **Ref**: Regulation 14 (4) **Stated:** First time	The registered person shall implement a system to ensure that patients' monies are not used to either purchase items or pay for additional services e.g. hairdressing, for those patients who have insufficient funds. The current practice of using patients' monies should cease immediately and the amount identified as owed should be reimbursed back to the monies held on behalf of patients. RQIA should be informed of the date when the monies have been reimbursed.	**Met**
	Action taken as confirmed during the inspection: On discussion with staff it was evident that a system had been implemented to ensure that patients' monies are not used to either purchase items or pay for additional services for those patients who have insufficient funds. On discussion with staff it was evident that the practice of using patients' monies had ceased and the amount identified as owed was reimbursed back to the monies held on behalf of patients.	
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time	The registered person shall review and revise the management of medicines which are provided for patients who are temporarily absent from the home.	**Carried forward to the next care inspection**
	Action taken as confirmed during the inspection: The manager advised that there had been no social leave since the last inspection. Staff had received supervision on the management of medicines for social leave i.e. labels and cartons were available for registered nurses to supply these medicines to the family members, a record of transfer of the medicines to the family to be maintained and records of administration to indicate that the patient was absent from the home at the time of the medicine round. A procedure for the management of medicines for social leave has been written and was awaiting ratification.	

	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.	
Area for improvement 2 **Ref**: Standard 28 **Stated:** First time	The registered manager shall implement a robust audit system for the management of medicines. Where shortfalls are identified, action plans to address these should be developed and implemented.	**Met**
	Action taken as confirmed during the inspection: Following discussion with the manager and a review of the action plans there was evidence that action plans to address shortfalls in the management of medicines had been developed and implemented.	
Area for improvement 3 **Ref**: Standard 14.25 **Stated:** First time	The registered person shall implement a system for reconciling patients' items held in the safe place at least quarterly. A record should be maintained to show that the items have been checked. The records should be signed by the person undertaking the reconciliation and countersigned by a second member of staff to evidence that they have taken place. The records should include the details of the items withdrawn from and returned to, the safe place, along with the dates the activity took place.	**Met**
	Action taken as confirmed during the inspection: On discussion with staff we were informed that there were no patients' items held in the safe place. Staff were able to discuss the appropriate measures as outlined above should patients' items need to be reconciled.	

Area for improvement 4 **Ref**: Standard 23 **Stated:** First time	The registered person shall ensure that where a patient requires repositioning a record is maintained to reflect the recommended frequency of repositioning as per care plan.	**Met**
	Action taken as confirmed during the inspection: Review of a sample of repositioning records evidenced that records were maintained to reflect the recommended frequency of repositioning as per care plan.	

6.2 Inspection findings

6.2.1 Staffing

On arrival to the home at 10.10 hours we were greeted by the manager and staff who were helpful and attentive. There was a pleasant, relaxed atmosphere in the home throughout the inspection and staff were observed to have cheerful and friendly interactions with patients.

The manager advised us of the daily staffing levels within each unit and how these levels were reviewed regularly to ensure the assessed needs of the patients were met. Review of staff duty rotas evidenced that the planned staffing levels had been adhered to.

A discussion with staff confirmed that they were satisfied with current staffing arrangements. Comments from staff included:

- “I feel very supported by management.”
- “Great teamwork.”
- “I love my job.”
- “Really happy working here.”
- “Great staff morale.”
- “Good induction.”

We also sought staff opinion on staffing via the online survey. There was no response in the time frame allocated.

6.2.2 Care delivery

Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Three Rivers Care Centre. Patients appeared comfortable around staff and were observed approaching staff with specific requests or just to chat. Comments from patients included:

- “We are all doing well. (Staff) are all good to me.”
- “Staff are looking after me well.”
- “Happy here.”
- “The food is good here.”

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and of how to provide comfort if required. Patients were supported by staff in maintaining their personal care in a timely and discreet manner; however, we observed a number of patients with long and/or unclean finger nails and on review of several personal care records we identified that staff had documented that they had provided nail care. We discussed this with the manager and during the inspection patients nail care was attended to by staff. The manager agreed to monitor this aspect of patient care during a daily walk around the home and to address this aspect of care with staff accordingly.

We observed the lunch time meal and saw that staff attended to the patients' needs in a prompt and timely manner. We saw that staff wore the appropriate Personal Protective Equipment (PPE) and sat beside patients when assisting them with their meal. However, there was no menu displayed within any of the dining areas to reflect the meals which were available. This was discussed with the manager and identified as an area for improvement.

6.2.3 Communication

We confirmed through discussion with patients and staff that systems were in place to ensure good communications between the home, patient and their relatives. Some examples of the efforts made included**:** video calls, telephone calls and a drive through visit.

Discussion with patients and staff and review of the activity programme evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. On the day of the inspection, the activity schedule was on display within each unit. The activity coordinator discussed the provision of activities and the current arrangements within the home to facilitate patient involvement in accordance with social distancing restrictions. The patients appeared to enjoy the interaction between the staff and each other.

6.2.4 Care records

There was evidence that care records were reviewed regularly and positive changes had been made by staff in an effort to personalise care plans; however, review of four patients' care records evidenced that some care plans were inaccurate, inconsistent or lacked sufficient detail. Also, one patient requiring enhanced supervision did not have a care plan or relevant deprivation of liberty safeguards (DoLS) trust panel agreement forms in place to reflect their assessed needs.

Specific examples were discussed in detail with management who acknowledged the shortfalls in the documentation and agreed to communicate with relevant staff the importance of accurately recording such information within patients' care records. In order to drive improvements, this was identified as an area for improvement.

6.2.5. Adult safeguarding

We discussed the current adult safeguarding referrals with the manager and reviewed the content of the information held within the adult safeguarding folder. The manager advised that the western health and social care trust (WHSCT) had recommenced monitoring visits to the home in the past two weeks and that remote strategy meetings were being scheduled to process the referrals to the appropriate stage.

On review of one patient's care records we identified that an initial protection plan which had been implemented following a referral several months previously had not been reviewed to reflect recent changes to the patient's plan of care and further identified that these changes had not been discussed with the patient's next of kin. This was discussed with the manager who agreed to address these issues and an area for improvement was made.

6.2.6 Infection prevention and control measures

We found that there was an adequate supply of PPE at the entrance to the home and PPE stations were well stocked throughout the units. On discussion with staff they advised that management were very proactive in ensuring there was a good supply of PPE throughout the home.

We were advised by staff that temperature checks were being completed on all patients and staff twice daily and that any deficits were reported to the manager and/or nurse in charge.

We discussed the provision of mandatory training specific to IPC measures with staff. Staff confirmed that they had access to online training and that the training provided them with the necessary skills and knowledge to care for the patients. Training records confirmed that staff had completed IPC training and that management were monitoring progress with overall mandatory training to ensure full compliance.

Staff demonstrated an awareness of the various types of PPE with the majority of staff observed applying and removing PPE correctly. However, we observed one staff member within a patient area not wearing a face mask and two further staff wearing a face mask incorrectly. This was discussed with the manager who agreed to monitor this practice during her daily walk around the home and to communicate with staff, as necessary.

6.2.7 Environment

In general, the environment was fresh smelling, neat and tidy. The manager discussed the recent refurbishment plans which have been delayed due to the COVID-19 restrictions but assured us that relevant work would commence as restrictions are relaxed.

Within the Strule unit we identified two fire doors that required a replacement battery. We further identified that the roof space door on the corridor of the Drumragh unit was damaged and brought this to the attention of the manager. Following the inspection, written confirmation was received that the batteries were replaced to both fire doors and the roof space door had been repaired.

We observed a domestic trolley unattended within the corridor of the dementia unit and brought this to the attention of the cleaner who acknowledged the importance of securing hazardous chemicals. This was discussed with the manager during feedback and an area for improvement was made.

A number of unoccupied bedrooms throughout the home were being used as temporary staff changing, dining and storage areas. The manager advised us that this was a temporary measure due to current COVID-19 restrictions. We discussed the importance of the rooms being used for the purpose that they were registered and requested written information regarding the location of the rooms and that this was a temporary measure during the COVID-

19 pandemic. Following the inspection, this information was received in writing from the manager.

6.2.8 Management of medicines

In addition to reviewing the quality improvement plan (see section 6.1), we reviewed the management of distressed reactions, pain and thickening agents.

The management of distressed reactions was reviewed for three patients. Care plans, which included details of known triggers, engagement strategies and prescribed medicines, were in place. The reason for and outcome of each administration was recorded and there was evidence that the care plans were reviewed monthly. Regular administration was required for one patient; the manager advised that this would be referred to the prescriber for review.

The management of pain was reviewed for three patients. Care plans, which included details of prescribed medicines, were in place. The manager advised that pain assessment tools were used with patients who could not verbalise their pain. The records examined indicated that care plans were reviewed at least monthly and medicines which were prescribed to manage pain had been administered as prescribed.

We reviewed the management of thickening agents for three patients. Records of prescribing and administration, care plans and speech and language assessment reports were in place for each patient. The prescribed consistency was noted to be recorded accurately on all records.

6.2.9 Leadership and management arrangements

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the manager's hours were not in keeping with the actual hours worked. This was discussed with the manager who agreed to ensure that the exact hours of work are reflected on the duty rota going forward. This will be reviewed at a future inspection.

We reviewed accidents/incidents records in comparison with the notifications submitted by the home to RQIA and identified that two notifications involving unwitnessed falls which resulted in a head injury had not been submitted in accordance with regulation. This was discussed with the manager and both notifications were submitted retrospectively. This was identified as an area for improvement.

On further review of accident records we identified inconsistencies within the recording of neurological observations following unwitnessed falls. This was discussed in detail with the manager and an area for improvement was identified.

We discussed staff training with the manager specific to the Mental Capacity Act (Northern Ireland) 2016 deprivation of liberty safeguards and were informed that the majority of staff had not completed level 2 training. Following the inspection written confirmation was received by RQIA that staff had been informed to complete the relevant training specific to their role, with ongoing monitoring to ensure full compliance. This will be reviewed at a future inspection.

The manager advised us that due to the COVID-19 restrictions and the reduced footfall within the home, monthly monitoring visits from the regional manager were not completed for March and April 2020 but ongoing support via telephone and short visits to the home continued.

Following the inspection a copy of the monthly monitoring report for May 2020 was forwarded to RQIA which provided an overview of the nursing home. The report reflected some of the above findings and an action plan with time frames and the person responsible for addressing the actions was implemented.

Areas of good practice

Evidence of good practice was found in relation to staffing arrangements. We observed friendly, supportive and caring interactions by staff towards patients and we were assured that there was a strong culture of compassionate care in the home.

Areas for improvement

Six new areas were identified for improvement. These were in relation to: the menu display, care records, adult safeguarding, control of substances hazardous to health (COSHH), submission of notifiable events and post fall management.

	Regulations	Standards
Total number of areas for improvement	4	2

6.3 Conclusion

There was evidence of appropriate leadership and management structures within the home and patients appeared to be content and settled in their surroundings. Staff were knowledgeable regarding the needs of patients and how to access relevant services to ensure that the needs of patients are met. We were satisfied that the appropriate action had been taken to address any immediate issues identified during the inspection. New areas for improvement are outlined in section 6.2.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Charlene Parkin, 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.

A completed Quality Improvement Plan from the inspection of this service is not currently available. However, it is anticipated that it will be available soon.

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

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005

Area for improvement 1 **Ref**: Regulation 12(b) **Stated:** Second time **To be completed by:** 23 August 2019	The registered person shall implement a system to ensure that records show the current balance of patients' monies held within the home at any time Ref: 6.1
	Response by registered person detailing the actions taken: Going forward a daily ledger recording balance and transactions of residents monies held in cash within the home will be recorded at close of Admin day.
Area for improvement 2 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** 18 July 2020	The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals. This is in specific reference to care plans and daily records: • accurately reflecting patients' level of assistance with mobilising • containing clear information regarding the recommended type of wound care dressing for patients • containing clear information regarding patients' recommended daily fluid intake • that patients requiring enhanced supervision have a care plan in place which is reflected within the patient's daily progress notes • that care plans specific to deprivation of liberty safeguards are personalised for each patient • that appropriate trust panel DoLS agreement forms are held within each patient's care folder, where applicable. Ref: 6.2.4
	Response by registered person detailing the actions taken: The homes management team continue to carry out daily walkarounds to each unit completing the associated checks of documentation in relation to daily care records such as fluid intake records and daily progress notes. These documentats are reviewed specifically for accuracy of information and standard of completion. In addition to the above care file audits continue to be carried out regularly and issues arising are highlighted to the named nurse for review and improvement. It has been communicated to all staff involved in direct care the importance of accurately recording of information within patients' care records.

Area for improvement 3 **Ref:** Regulation 14 (2) (a) (c) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all chemicals are securely stored in keeping with COSHH legislation to ensure that patients are protected at all times from hazards to their health. Ref: 6.2.7
	Response by registered person detailing the actions taken: All domestic staff have been reminded of the importance of ensuring that trolleys should not be left unattended and where trolleys are outside of bedroom doors the door should always remain open so that the member of staff always has sight of same. This is further checked and monitored via the daily manager spot checks and recorded as corrective action as necessary.
Area for improvement 4 **Ref:** Regulation 30 (d) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall give notice to the Regulation and Improvement Authority without delay of the occurrence of any event in the nursing home which adversely affects the wellbeing or safety of any patient. Ref: 6.2.9
	Response by registered person detailing the actions taken: Following inspection the Accidents and Incidents records were fully reviewed and the two notifications for head injury were submitted to the inspector retrospectively. All incidents and accidents witnessed and unwitnessed are now reviewed by the Home manager and notifications submitted in a timely manner.
Area for improvement 5 **Ref:** Regulation 13 (1) (a)(b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that all unwitnessed falls are managed in line with current best practice and that neurological observations are obtained. Ref: 6.2.9
	Response by registered person detailing the actions taken: Neurological observations are recorded following unwitnessed falls to assess and monitor for signs or symptoms of potential head injury. Whilst there were neurological records to reflect the observations, there were issues in lack of recording were residents refused or there was an identified clinical reason. Following inspection all staff have been reminded that they must record, clearly and concisely the reason for not having completed the check.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time	The registered person shall review and revise the management of medicines which are provided for patients who are temporarily absent from the home. Ref: 6.1

To be completed by: 23 August 2019	**Action required to ensure compliance with this standard was not reviewed as part of this inspection and this will be carried forward to the next care inspection.**
Area for improvement 2 **Ref**: Standard 12 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the daily menu is displayed to reflect the meal choices available. Ref: 6.2.2
	Response by registered person detailing the actions taken: On the day of the inspection the menu for the Breakfast service was displayed and had not been reset for the lunch service. Following inspection the manager had fully reviewed the menu display and provided a new version for ease of use for both residents and staff. Menus are now clearly displayed and the oversight of this has been allocated to the Head Chef to ensure that they correctly reflect the meal served.
Area for improvement 3 **Ref**: Standard 13 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that adult safeguarding protection plans are: • kept under regular review and updated when necessary • discuss any changes with the patient, care manager and next of kin. Ref: 6.2.5
	Response by registered person detailing the actions taken: Whilst the responsibility for the formulation and update of any implemented Adult Protection Plan lies with the Trust gateway team, Management will ensure that any communications with the team, verbal or via email in relation to same will be made available in the Adult Safeguard file or residents care plan as appropriate to maintian a concise, up to date progress of any ongoing cases.

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

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