Inspection Report

21 October 2021

Three Rivers Care Centre

Type of Service: Nursing Home (NH)
Address: 11 Millbank Lane, Lisnamallard, Omagh BT79 7YD
Tel No: 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 Care Homes Ltd **Responsible Individual:** Mr Philip Scott	**Registered Manager:** Ms Jillian Claire McKenna, Acting
Person in charge at the time of inspection: Ms Jillian Claire McKenna	**Number of registered places:** 56 This number includes: • a maximum of 28 patients in category NH-DE which includes three named residents under RC-DE accommodated in the Strule Unit • a maximum of 28 patients in category NH-I and a maximum of four 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:** 40
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 provides dementia nursing care on the ground floor. Drumragh unit, on the first floor, 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 21 October 2021 from 10.15 am to 3.10 pm. The inspection was conducted by a pharmacist inspector and focused on medicines management within the home.

The inspection also assessed progress with any areas for improvement identified since the last care inspection.

Review of medicines management found that patients were administered their medicines as prescribed. There were arrangements for auditing medicines and medicine records were well maintained. Systems were in place to ensure that staff were trained and competent in medicines management. Areas for improvement were identified in relation to the management of thickening agents and distressed reactions including care planning.

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, information held by RQIA about this home was reviewed. This included previous inspection findings, incidents and correspondence. To complete the inspection the following were reviewed: a sample of medicine related records, storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines. We also spoke to staff and management about how they plan, deliver and monitor the management of medicines in the home.

4.0 What people told us about the service

We met with three nurses and the manager. Staff were warm and friendly and it was evident from discussions that they knew the patients well. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

The nurses expressed satisfaction with how the home was managed and the training received. They said that the team communicated well and the manager was readily available to discuss any issues and concerns should they arise.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. Four questionnaires were returned. All responses were positive indicating that they were "satisfied" or "very satisfied" with the care provided.

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 8 September 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.	**Carried forward for review at the next inspection**
	All parts of the home accessed by the inspector were observed to be free from hazards. However, this area for improvement was not assessed fully. **Action required to ensure compliance with this regulation was not fully reviewed as part of this inspection and this is carried forward to the next inspection.**	
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.	**Carried forward for review at the next inspection**
	The inspector did not observe any deficits in infection prevention and control (IPC). However, this area for improvement was not fully assessed. **Action required to ensure compliance with this regulation was not fully reviewed as part of this inspection and this is carried forward to the next inspection.**	
Area for improvement 3 **Ref:** Regulation 29 **Stated:** First time	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.	**Carried forward for review at the next inspection**
	Action taken as confirmed during the inspection: The monthly monitoring visit had been completed in September 2021. A copy had	

	been forwarded to RQIA. **Action required to ensure compliance with this regulation was reviewed as part of this inspection, however it was carried forward for review until further notice.**	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 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.	**Met**
	Action taken as confirmed during the inspection: The manager advised that it had not been necessary to provide medicines to patients/their families for administration while temporarily absent from the home. A policy was in place in order to ensure that medicines would be managed safely during any temporary absences from the home. The manager advised that nurses were aware of this policy. Due to the action taken and assurances provided this area for improvement was assessed as met.	
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.	**Carried forward for review at the next inspection**

	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	
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.	**Carried forward for review at the next inspection**
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	
Area for improvement 4 **Ref:** Standard 12 **Stated:** First 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.	**Not met**
	Action taken as confirmed during the inspection: On the day of the inspection nurses were unable to confirm the recommended consistency level for one patient. The recommendation level was not accurately recorded on all records. (See Section 5.2.1). **This area for improvement has not been met and is stated for a second time.**	
Area for improvement 5 **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.	**Carried forward for review at the next inspection**

	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.	

5.2 Inspection findings

5.2.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs will change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by a community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews and hospital appointments.

The majority of the personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second nurse had verified and signed the personal medication records when they were written and updated to provide a check that they were accurate.

Copies of patients' prescriptions/hospital discharge letters were retained in the home so that any entry on the personal medication record could be checked against the prescription.

All patients should have care plans which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets, self-administration etc.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines prescribed on a "when required" basis for distressed reactions was reviewed. Nurses on duty knew how to recognise signs, symptoms and triggers which may cause a change in each patient's behaviour and were aware that this change may be associated with pain. However, this detail was not recorded in each patient's care plan.

An area for improvement was identified. Directions for use were recorded on the personal medication records and records of administration were maintained. The reason for and outcome of administration were recorded on the majority of occasions.

The management of pain was discussed. Nurses advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans were in place which included details of the reason for chronic pain and the prescribed medicines.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

The management of thickening agents was reviewed for five patients. For four of the patients, speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were accurately maintained. However, as identified at the inspection on 8 September 2021 for one patient the consistency level recorded on their personal medication record did not correlate with that recorded on their care plan, medication administration record or fluid intake chart. Management confirmed via email following the inspection that the personal medication record was correct and that the patient had been administered the correct fluid consistency. The area for improvement identified at the last inspection was stated for a second time.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral tube. The management of medicines and nutrition via the enteral route was reviewed for one patient. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

Generic care plans were in place for patients who required insulin to manage their diabetes. It was agreed that further detail specific to each patient would be recorded in the care plans. Nurses were reminded that insulin pens should be individually labelled and the date of opening recorded in order to facilitate audit and disposal at expiry.

A small number of patients have their medicines administered covertly in food/drinks to assist administration. This had been authorised by the prescriber, in consultation with the families, care manager and manager. Care plans were not in place to provide the details on how each medicine was to be administered. This was discussed with the nurses on duty who agreed to write the care plans immediately following the inspection.

5.2.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicines stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

The records inspected showed that medicines were available for administration when patients required them. Staff advised that they had a good relationship with the community pharmacist and that medicines were supplied in a timely manner.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located.

The temperature of one medicine refrigerator was observed to be outside the required range (2^{o}C to 8^{o}C). Nurses had taken appropriate corrective action and a replacement refrigerator had been made available. Assurances were provided that further corrective action would be taken if necessary.

Appropriate arrangements were in place for the disposal of medicines.

5.2.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

Within the home, a record of the administration of medicines was completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. The records had been completed in a satisfactory manner. There was evidence that systems were in place to ensure that any missed signatures for administration were brought to the attention to the relevant nurses for corrective action. A small number of differences between the personal medication records and pre-printed medication administration records were brought to the attention of the nurses and manager for corrective action and ongoing close monitoring. The medicines had been administered as prescribed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs were recorded in a controlled drug record book. Robust arrangements were in place for the management of controlled drugs.

Management and staff audited the management and administration of medicines on a regular basis. Where shortfalls had been identified action plans were developed and implemented.

The audits completed at the inspection indicated that medicines were administered as prescribed. Some minor discrepancies were discussed for ongoing close monitoring.

5.2.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is

transferred put people at increased risk of harm when they change from one healthcare setting to another.

The management of medicines for recently admitted patients or patients returning to the home following discharge from hospital was reviewed. There was evidence that robust arrangements were in place to ensure that written confirmation of the patients' current medicine regime was obtained and the GP and community pharmacy were contacted as necessary. Personal medication records had been accurately written. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

5.2.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident.

The audit system in place helps staff to identify medicine related incidents. One recent medication incident had been investigated and action taken to prevent a recurrence. However, the incident had not been reported to the care manager or RQIA. An incident report was received by RQIA on 22 October 2021 and assurances were provided that any future medication related incidents would be reported to RQIA in a timely manner.

5.2.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that staff are supported. Policies and procedures should be up to date and readily available.

Staff in the home had received a structured induction which included medicines management when this forms part of their role. Competency had been assessed following induction and annually thereafter.

Records of staff training in relation to medicines management were available for inspection.

6.0 Conclusion

The inspection sought to assess if the home was delivering safe, effective and compassionate care and if the home was well led in relation to medicines management.

We can conclude that overall patients were being administered their medicines as prescribed. However, one area for improvement in relation to the management of thickening agents was stated for a second time and improvements in medicine related care plans were also necessary.

We would like to thank the patients and staff for their assistance throughout the inspection.

7.0 Quality Improvement Plan/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, April 2015.

	Regulations	Standards
Total number of Areas for Improvement	3*	5*

* the total number of areas for improvement includes one which has been stated for a second time and six which have been carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Claire McKenna, 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 Home Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) (a) **Stated:** First time **To be completed by:** With immediate effect (8 September 2021)	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. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect (8 September 2021)	The registered person shall ensure that IPC deficits identified during the inspection are addressed. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Area for improvement 3 **Ref:** Regulation 29 **Stated:** First time **To be completed by:** With immediate effect (8 September 2021)	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. **Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Action required to ensure compliance with Care Standards for Nursing Homes, April 2015	
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. Ref: 5.1 & 5.2.1

To be completed by: With immediate effect (8 September 2021)	**Response by registered person detailing the actions taken:** SALT recommendations were clarified for the patient identified on the day of inspection and any discrepancies amended within care plans and diet/fluid type quick reference charts. An instant communication reminder to all staff of updated diet/fluid types was also sent in the home group whatsapp.
Area for improvement 2 **Ref:** Standard 23 **Stated:** First time **To be completed by:** 8 October 2021	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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
Area for improvement 3 **Ref:** Standard 12 **Stated:** First time **To be completed by:** With immediate effect (8 September 2021)	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.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection. Ref: 5.1
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.

To be completed by: With immediate effect (8 September 2021)	**Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.** Ref: 5.1
Area for improvement 5 **Ref:** Standard 18.9? **Stated:** First time **To be completed by:** With immediate effect (21 October 2021)	The registered person shall ensure that care plans for the management of distressed reactions contain sufficient detail to direct the required care. Ref: 5.2.1
	Response by registered person detailing the actions taken: All nurses have been advised of the expected level of detail required within care plans for distressed reactions, paying particular attention to potential triggers/causes, the reason for administration and outcome effect.

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

The Regulation and Quality Improvement Authority

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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