The Regulation and Quality Improvement Authority

# Inspection Report

# 15 July 2021

# Rivervale Country

Type of service: Nursing Home
Address: 56a Dunamore Road, Cookstown, BT80 9NT
Telephone number: 028 8675 1787

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:**<br>Rivervale Country<br><br>**Responsible Individual:**<br>Ms Cecilia Theresa O'Neill | **Registered Manager:**<br>Ms Helena Margaret O'Neill<br><br>**Date registered:**<br>1 April 2005 |
|---|---|
| **Person in charge at the time of inspection:**<br>Ms Helena Margaret O'Neill | **Number of registered places:**<br>20<br><br>This number includes a maximum of five patients in category NH-DE. |
| **Categories of care:**<br>Nursing (NH):<br>I – old age not falling within any other category<br>PH – physical disability other than sensory impairment<br>DE – dementia<br>MP – mental disorder excluding learning disability or dementia<br>MP(E) – mental disorder excluding learning disability or dementia – over 65 years<br>PH(E) - physical disability other than sensory impairment – over 65 years<br>TI – terminally ill | **Number of patients accommodated in the nursing home on the day of this inspection:**<br>14 |
| **Brief description of the accommodation/how the service operates:**<br>This is a nursing home which is registered to provide care for up to 20 patients. | |

## 2.0 Inspection summary

An unannounced inspection took place on 15 July 2021 between 10.30 am and 1:15 pm. This inspection was conducted by a pharmacist inspector.

This inspection focused on medicines management within the home.

## 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 a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines was reviewed.

## 4.0 What people told us about the service

The inspector met with the manager and the responsible person. All staff were wearing face masks and other personal protective equipment (PPE) as needed. PPE signage was displayed.

Staff were warm and friendly and it was evident from their interactions that they knew the patients well.

In order to reduce footfall throughout the home, the inspector did not meet with any patients. Feedback methods included a staff poster and paper questionnaires which were provided to the registered manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no questionnaires had been received by RQIA.

## 5.0 The inspection

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

The last inspection to the nursing home was undertaken on 4 March 2021 by a care inspector; no areas for improvement were identified.

### 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 the 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, medication reviews or hospital appointments.

Some of these records reviewed were not up to date with the most recent prescription and were incomplete. Recent medication changes had not been updated on the personal medication records and some medicines which had been prescribed for acute short term conditions had not been discontinued. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that nurses did not use these records as part of the administration of medicines process. An area for improvement was identified.

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. This is good practice.

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 nurses 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 nurses 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.

We reviewed the management of medicines prescribed on a "when required" basis for the management of distressed reactions for one patient. Nurses knew how to recognise signs, symptoms and triggers which may cause a change in a patient's behaviour and were aware that this change may be associated with pain. Although a care plan directing the use of these medicines was available in the medicines file, directions for use were not clearly recorded on the personal medication records. Records of administration were clearly recorded, however, the reason for and outcome of administration were not routinely recorded in the daily progress notes and on incident report forms. An area for improvement was identified.

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.

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.

We reviewed the management of thickening agents for two patients. Speech and language assessment reports and care plans were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

### 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 arrangements for the disposal of medicines were appropriate and records were maintained.

### 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 is completed on pre-printed medicine administration records (MARs) or occasionally handwritten MARs. A sample of these records was reviewed. The records were found to have been fully and accurately completed. The records were filed once completed and were readily retrievable for audit/review.

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 are recorded in a controlled drug record book. Robust arrangements were in place for the management of controlled drugs and records were maintained to the required standard.

### 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.

We reviewed the management of medicines for one patient who was recently admitted to the home for a period of respite care. The patient's own medicines had been received into the home and were administered in accordance with the directions on the labels. An accurate list of currently prescribed medicines had not been obtained from the GP or community pharmacy and hence nurses could not be sure that the patient was administered all of their prescribed medicines or a discontinued medicine/incorrect dose. An area for improvement was identified.

### 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.

There have been no medicine related incidents reported to RQIA since the last inspection. The findings of this inspection indicate that the current auditing system is not robust and hence incidents may not be identified. The audits completed by the inspector indicated that the majority of medicines were administered as prescribed.

The need for a robust audit system which covers all aspects of medicines is necessary to ensure that safe systems are in place and any learning from errors/incidents can be actioned and shared with relevant staff. An area for improvement was identified.

### 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 for staff.

Records of staff training in relation to medicines management were available for inspection. The manager was currently reviewing staff competencies and indicated further medicines management training was arranged for the near future.

## 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.

The outcome of this inspection concluded that improvements in some areas for the management of medicines were necessary. Areas for improvement are detailed in the Quality Improvement Plan and include maintaining accurate personal medication records,

implementing a robust audit system, management of medicines for new admissions and the management of distressed reactions.

Whilst we identified areas for improvement, we can conclude that overall, the patients were being administered their medicines as prescribed.

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 Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015.

| | Regulations | Standards |
|---|---|---|
| **Total number of Areas for Improvement** | 0 | 4 |

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Helena O'Neill, Registered Manager, and Ms Teresa O'Neill, Responsible Individual, 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 Care Standards for Nursing Homes, April 2015 | |
|---|---|
| **Area for improvement 1**<br><br>**Ref**: Standard 29<br><br>**Stated:** First time<br><br>**To be completed by:**<br>From the date of inspection | The registered person should ensure fully complete and accurate personal medication records are maintained.<br><br>Ref: 5.2.1 |
| | **Response by registered person detailing the actions taken:**<br>Staff have been retrained to ensure that fully completed and accurate personal medication records are maintained. |
| **Area for improvement** 2<br><br>**Ref:** Standard 29<br><br>**Stated:** First time<br><br>**To be completed by:**<br>From the date of inspection | The registered person should ensure that the reason for and outcome of administration of medicines prescribed to be administered when required for distressed reactions are routinely recorded.<br><br>Ref: 5.2.1 |
| | **Response by registered person detailing the actions taken:**<br>Staff have been retrained on recording the reason for and the outcome of a medication prescribed and administered to a patient for distressed reactions, and the outcome each time this medicine is administered. |
| **Area for improvement 3**<br><br>**Ref:** Standard 28<br><br>**Stated:** First time<br><br>**To be completed by:**<br>From the date of inspection | The registered person should ensure that an accurate list of medicines is obtained from the GP for patients newly admitted to the home.<br><br>Ref: 5.2.4 |
| | **Response by registered person detailing the actions taken:**<br>All staff have been instructed regarding obtaining an accurate list of medications from the relevant GP before any patient is admitted to the home. |
| **Area for improvement 4**<br><br>**Ref:** Standard 28<br><br>**Stated:** First time<br><br>**To be completed by:**<br>From the date of inspection | The registered person shall develop and implement a robust auditing system for medicines management.<br><br>Ref: 6.4 |
| | **Response by registered person detailing the actions taken:**<br>A new auditing system has been developed and staff have been instructed of their role in Medicine Management. |

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