Unannounced Care Inspection Report
6 February 2017

Rivervale Country

Type of Service: Nursing Home
Address: 56a Dunamore Road, Cookstown, BT80 9NT
Tel no: 02886751787
Inspector: Aveen Donnelly

1.0 Summary

An unannounced inspection of Rivervale took place on 6 February 2017 from 09.15 to 16.30 hours.

The inspection sought to assess progress with any issues raised, during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

On the day of inspection patients, relatives and staff spoken with commented positively in regard to the care in the home. A review of records, discussion with the registered manager and staff and observations of care delivery evidenced that the majority of the requirements and recommendations made as a result of the previous inspection have been complied with.

Three recommendations were made as a result of this inspection.

Throughout the report the term 'patients' is used to describe those living in Rivervale which provides both nursing and residential care.

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.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	1	4

The total number of requirements and recommendations above includes one requirement and one recommendation that have been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Helena O'Neill, registered manager and Theresa O'Neill, responsible person, 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.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 17 November 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Rivervale Country Helena Margaret O'Neill Cecelia Theresa O'Neill	**Registered manager:** Helena Margaret O'Neill
Person in charge of the home at the time of inspection: Helena Margaret O'Neill	**Date manager registered:** 1 April 2005
Categories of care: RC-DE, RC-I, RC-MP(E), RC-PH(E), RC-MP, RC-PH, NH-DE, NH-I, NH-PH, NH-PH(E), NH-MP, NH-MP (E) A maximum of 3 persons in residential categories. No more than 1 resident in category RC-DE and no more than 5 patients in category NH-DE	**Number of registered places:** 20

3.0 Methods/processes

Specific methods/processes used in this inspection include the following:

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken.

Questionnaires were distributed to patients, relatives and staff. We also met with three patients, one care staff, two registered nurses and one patients' representative.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- three patient care records
- staff training records
- accident and incident records
- records relating to adult safeguarding
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005
- complaints received since the previous care inspection

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 17 November 2016.

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacist inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered provider/s, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 4 August 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 14 (4) **Stated:** First time	The registered persons must ensure that all staff are made aware the home's policies and procedures and regional safeguarding protocols in relation to adult safeguarding. A flowchart should be developed and made available for all staff, which illustrates clearly the procedure to follow when reporting actual or potential safeguarding incidents.	**Met**
	Action taken as confirmed during the inspection: Discussion with staff and a review of the safeguarding protocols evidenced that this recommendation had been met. A flowchart was available and the contact details for the relevant adult safeguarding teams were available for all staff.	

Requirement 2 **Ref:** Regulation 30 (1) (d)(g) **Stated:** First time	The registered persons must ensure that all actual or potential safeguarding incidents are reported in line with regional safeguarding protocols. Records pertaining to any allegation of abuse must be appropriately maintained.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and a review of records confirmed that any actual or potential safeguarding incident had been reported in line with regional protocols.	
Requirement 3 **Ref:** Regulation 13 (7) **Stated:** First time	The registered persons must ensure that infection prevention and control practices are reviewed and monitored to ensure compliance with best practice in infection prevention and control within the home.	**Met**
	Action taken as confirmed during the inspection: Infection prevention and control measures were adhered to and there was evidence that infection prevention and control audits were undertaken on a regular basis.	
Requirement 4 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time	The registered persons must ensure that the patients' needs are assessed with particular reference to wound and/or pressure care management.	**Met**
	Action taken as confirmed during the inspection: Where a patient required a wound to be dressed, there was evidence of regular wound assessments. The treatment regime was included in the care record and there was evidence that referrals were made to the tissue viability nurse specialist, as appropriate.	
Requirement 5 **Ref:** Regulation 15 (2)(a) **Stated:** First time	The registered persons must ensure that accurate records are maintained in regards to patients' bowel patterns. Bowel records must be monitored by registered nurses and records maintained of any action taken.	**Not Met**

	Action taken as confirmed during the inspection: A review of the bowel monitoring records evidenced that bowel records were not accurately maintained and there was a lack of evidence that the bowel records were being monitored by the registered nurses. This requirement was not met and has been stated for the second time. Refer to section 4.3.2 for further detail.	
Requirement 6 **Ref:** Regulation 13 (8) (a) **Stated:** First time	The registered persons must ensure that the practice of using camera monitors is reviewed to ensure compliance with the home's policy and procedure and RQIA's Guidance on the use of Overt Close Circuit Televisions (CCTV).	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager and observation on the day of the inspection evidenced that the practice of using monitors had ceased.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref**: Standard 32.1 **Stated:** Second time	The following policies and guidance documents should be developed and made readily available to staff: • A policy on communicating effectively in line with current best practice, such as DHSSPSNI (2003) *Breaking Bad News.* • A policy on palliative and end of life care in line with current regional guidance, such as GAIN (2013) *Palliative Care Guidelines which* should include the referral procedure for specialist palliative care nurses; the procedure for managing shared rooms; the process for notifying RQIA in the event of a death; and management of a sudden or unexpected death. **<u>The above policies should be submitted to RQIA with the returned QIP.</u>**	**Met**
	Action taken as confirmed during the inspection: A review of the above policies confirmed that they had been updated in line with this recommendation.	

Recommendation 2 **Ref**: Standard 21 **Stated:** First time	The registered persons should ensure that wound care records are supported by the use of photography in keeping with the home's policies and procedures and the NICE guidelines.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manger confirmed that processes were in place to ensure that wound photography would be used to support the wound assessment process.	
Recommendation 3 **Ref**: Standard 23.5 **Stated:** First time	The registered persons should ensure that the records of equipment checks are further developed, to include recording of the individual setting specified for each pressure relieving mattress.	**Partially Met**
	Action taken as confirmed during the inspection: A review of the equipment checks records evidenced that although some patients had records maintained in relation to the mattress settings, this was not consistently maintained. Discussion with the registered manager confirmed that advice was being sought from the suppliers of specific mattresses, to ensure that there was clear guidance available to the staff, in relation to the individual settings. This recommendation was partially met and has been stated for the second time.	
Recommendation 4 **Ref**: Standard 4 **Stated:** First time	The registered persons should ensure that registered nursing staff, receive training in developing care plans. This training must also address the deficits in contemporaneous recording observed in this inspection, in accordance with NMC guidelines for record keeping and should include the legal aspects of care planning and record keeping.	**Met**
	Action taken as confirmed during the inspection: A review of training records confirmed that training had been provided in line with this recommendation. A review of the care records confirmed that records were maintained in line with best practice.	

Recommendation 5 **Ref**: Standard 1.3 **Stated:** First time	The registered persons should ensure that the pre-admission process is further developed, to ensure that a comprehensive assessment of nursing care needs is undertaken to determine prospective patients' care needs.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered persons confirmed that a new preadmission assessment document was in the process of being developed. A review of one patient's care record evidenced that there was sufficient information in place, prior to admission to the home, to ensure that their needs would be met.	
Recommendation 6 **Ref**: Standard 35 **Stated:** First time	The registered persons should ensure that registered nurses with responsibility of being in charge of the home, in the absence of the registered manager, are able to access all information, as requested by the regulator. This refers particularly to information regarding NISCC registrations, supervision and appraisal records, induction records, complaints records and any audits undertaken by the registered manager.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered persons confirmed that plans were in place to ensure that all records required by the regulator would be available, in the event that the registered persons were not available.	

4.3 Inspection findings

4.3.1 Staffing arrangements

The registered manager confirmed the planned daily staffing levels for the home and stated that these levels were subject to regular review to ensure the assessed needs of the patients were met. Discussion with patients and staff evidenced that there were no concerns regarding staffing provision within the home. Observation of the delivery of care evidenced that patients' needs were met by the number and skill mix of staff on duty. A review of the staffing rota for the week commencing 30 January 2016 evidenced that the planned staffing levels were generally adhered to. However, there were two time-periods where the staffing levels fell below those discussed with the inspector. This was discussed with the registered persons, who provided clarification on the cover arrangements on those days. The cover arrangements were not clear from the duty rota. A recommendation has been made in this regard.

The registered manager explained there was currently three permanent nurse vacancies and that the vacancies were being filled by bank staff or agency staff. One care staff had been recently recruited and was going through the appropriate checks before starting in post.

Areas for improvement

A recommendation has been made that the duty rota is accurately maintained.

Number of requirements	0	Number of recommendations	1

4.3.2 Care delivery and practice

There was a calm atmosphere in the home and patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. The patients were observed to be sitting in either of the two lounges, or in their bedroom, as was their personal preference. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients, as was required from time to time.

A review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. Risk assessments generally informed the care planning process and there was evidence that the care plans were very person-centred. For example, information in relation to a patient's recent bereavement was included in their care plan, to ensure that the staff gave the patient additional support, as may be required. Where patients required their diets to be modified due to poor swallowing ability and risk of choking, the specific consistency of food and fluids was included in the care plan. Mobility care plans also reflected the information recorded on the moving and handling risk assessment and specified additional support the staff should be aware of, when assisting the patient to mobilise.

Personal care records evidenced that records were maintained in accordance with best practice guidance, care standards and legislative requirements. For example, a review of repositioning records evidenced that patients were repositioned according to their care plans and a sampling of food and fluid intake charts confirmed that patients' fluid intake had been monitored.

However, areas for improvement were identified. As discussed in section 4.2 a requirement had previously been made in relation to maintaining accurate bowel records and monitoring by

registered nurses. A review of the bowel records evidenced gaps in completion. There was also a lack of evidence within the care records that the registered nurses had oversight of the bowel records. The requirement was not met and has been stated for a second time. Further review of one patient's care record confirmed that a continence assessment or care plan was not in place and there was no evidence that a baseline assessment had been obtained in relation to the patient's normal bowel pattern. This was discussed with the registered manager. A recommendation has also been made in this regard.

Areas for improvement

A recommendation has been made that that bowel function, reflective of the Bristol Stool Chart, should be recorded on the patients' continence assessment, as a baseline measurement and thereafter included in the patients' care plan.

Number of requirements	0	**Number of recommendations**	1

4.3.3 Consultation

During the inspection, we met with three patients, one care staff, two registered nurse and one patient's representatives. Some comments received are detailed below:

Staff

"It is excellent here, all the patients are treated as individuals, everybody is happy here"
"I would not be here this long if I was not happy, it is excellent and I can compare it to other homes"
"I have no concerns, the care is good"

Patients

"It is very good"
"I have no complaints, I was very happy to come back here"
"It is very good"

Patients' representatives

"'It is absolutely fantastic here"

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. One staff, two patients and eight relatives had returned their questionnaires, within the timeframe for inclusion in this report.

All respondents indicated that they were 'very satisfied' that the care was safe, effective and compassionate; and that the home was well led. Some patients' comments included 'the staff are very kind and good and are always there immediately to help', 'visitors are always accommodated and my privacy to see visitors is respected' and 'what a great bunch of staff, I can get up when I want and go to bed when I want'.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.3.4 Management and governance arrangements

All those consulted with knew who the registered manager and responsible person were and stated that they were available at any time if the need arose. Written comment received on the returned questionnaires included ' staff and management are always ready and willing to help in any way' and ' I feel that management is always about and actively work with staff on the floor and with the patients'. Another comment included all staff are very approachable and inspire confidence with their knowledge and expertise'. There was a system in place to identify the person in charge of the home, in the absence of the registered manager.

Action had been taken to improve the effectiveness of the care following the last inspection. A review of records, discussion with the registered manager and staff and observations of care delivery evidenced that the majority of requirements and recommendations made as a result of the previous inspection have been complied with. Three recommendations were made as a result of this inspection.

Observation of patients evidenced that the home was operating within its registered categories of care. The registration certificate was up to date and displayed appropriately.

The registered persons confirmed that the policies and procedures for the home were currently being reviewed by an external consultant, to ensure that they were in line with legislative requirements and best practice guidance. Discussion with the registered persons also evidenced that plans were in place to reorganise the storage arrangements at the nurses' station and that they intended to implement an electronic system for assessing, planning and evaluating patients' care needs. However, on the day of the inspection, anyone passing by the nurses' station could have access to the content of the patient care records. This was discussed with management during feedback. A recommendation has been made to ensure that consideration is given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

A review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement

A recommendation has been made to ensure that consideration is given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times.

Number of requirements	0	Number of recommendations	1

4.3.5 Environment

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean and warm throughout. Infection prevention and control measures were adhered to. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Helena O'Neill, registered manager and Teresa O'Neill, responsible person, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained 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.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
Requirement 1 **Ref**: Regulation 15 (2)(a) **Stated:** Second time **To be completed by:** 6 April 2017	The registered persons must ensure that accurate records are maintained in regards to patients' bowel patterns. Bowel records must be monitored by registered nurses and records maintained of any action taken. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: A revised bowel record has been put in place to record more accurately patients bowel patterns. Staff have been retrained and registered nurses made aware they must monitor records and record any action taken in patients care records.
Recommendations	
Recommendation 1 **Ref**: Standard 23.5 **Stated:** Second time **To be completed by:** 6 April 2017	The registered persons should ensure that the records of equipment checks are further developed, to include recording of the individual setting specified for each pressure relieving mattress. **Ref: Section 4.2**
	Response by registered provider detailing the actions taken: Pumps for pressure relieving mattresses have been checked against manuals, and manufactures recommendations to ensure that the settings of each pump is accurate to each individual mattress in accordance with their weight. Records will be maintained and staff have been advised to monitor and record settings to ensure the appropriate and accurate setting is maintained.
Recommendation 2 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 6 April 2017	A recommendation has been made that the duty rota is accurately maintained. **Ref: Section 4.3.1**
	Response by registered provider detailing the actions taken: The duty rota will be accurately maintained.

Recommendation 3 **Ref**: Standard 21.6 **Stated:** First time **To be completed by:** 6 April 2017	A recommendation has been made that that bowel function, reflective of the Bristol Stool Chart, should be recorded on the patients' continence assessment, as a baseline measurement and thereafter included in the patients' care plan. **Ref: Section 4.3.2**
	Response by registered provider detailing the actions taken: Patient bowel function will be reflective of the Bristol Stool chart and recorded in their continence assessment, as a baseline measurement. A 7 day chart, showing the baseline bowel pattern has now been developed and will be used.
Recommendation 4 **Ref**: Standard 37.1 **Stated:** First time **To be completed by:** 6 April 2017	A recommendation has been made to ensure that consideration is given to how confidential patient information is retained to support and uphold patients' right to privacy and dignity at all times. **Ref: Section 4.3.4**
	Response by registered provider detailing the actions taken: We are currently reviewing our policies in relation to recording and retaining patient records and information. We are currently updating the encryption of patient data as stored on our sytems. This will be further enhanced by the introduction of our new computerised care planning system.

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