The Regulation and Quality Improvement Authority

Inspection Report

25 January 2022

Rivervale Country

Type of Service: Nursing Home (NH)
Address: 56a Dunamore Road, Cookstown, BT80 9NT
Tel No: 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: Rivervale Country **Responsible Individual** Ms Theresa O'Neill	**Registered Manager:** Ms Helena O'Neill **Date registered:** 01 April 2005
Person in charge at the time of inspection: Registered Nurse Janetta Norkute	**Number of registered places:** 20 A maximum of 5 patients in category NH-DE.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. MP – Mental disorder excluding learning disability or dementia. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 10
Brief description of the accommodation/how the service operates: This is a Nursing Home which is registered to provide care for up to 20 patients, which includes five patients living with dementia. The home is a two storey building with bedrooms located across both floors. There are two lounges and a dining room on the ground floor.	

2.0 Inspection summary

An unannounced inspection took place on 25 January 2022 from 10:00am to 3:35pm by a care Inspector.

The inspection was undertaken to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

The outcome of the inspection confirmed that the care in Rivervale Country was delivered in a safe, effective and compassionate manner. The service was well led with a clear management structure and systems in place to provide oversight of the delivery of care.

Patients were content and provided examples of what they liked about living in Rivervale Country. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Systems were in place to ensure that patients' needs were communicated to staff and observations confirmed that care was being delivered effectively to meet the needs of the patients. Care records provided details of the care each patient required and were reviewed regularly to reflect the changing needs of the patients.

As a result of this inspection an area for improvement was identified with the signing of repositioning charts.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the service provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from residents, relatives, staff or the Commissioning Trust.

Throughout the inspection patients and staff were asked for their opinion on the quality of the care; and their experience of living or working in this home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine the effectiveness of care delivery and the systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give residents and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

At the end of the inspection the Responsible Individual was provided with details of the findings.

4.0 What people told us about the service

Patients said they were content, well looked after and that they enjoyed the food. One patient described the home as "first class". The atmosphere in the home was unhurried and social. Due to the nature of dementia some patients found it difficult to share their thoughts on their life in the home. However all of the patients were well presented smiled when spoken with and were relaxed in the company of staff.

Staff told us there was good team work between staff and that they felt well supported by the management team. Staff recognised that this was the patients' home and the importance of ensuring that they were cared for in a respectful manner.

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 15 July 2021		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 29 **Stated:** First time	The registered person should ensure fully complete and accurate personal medication records are maintained. **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.**	**Carried forward to the next inspection**
Area for Improvement 2 **Ref:** Standard 29 **Stated:** First time	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. **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.**	**Carried forward to the next inspection**
Area for Improvement 3 **Ref:** Standard 28 **Stated:** First time	The registered person should ensure that an accurate list of medicines is obtained from the GP for patients newly admitted to the home. **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.**	**Carried forward to the next inspection**
Area for improvement 4 **Ref:** Standard 28 **Stated:** First time	The registered person shall develop and implement a robust auditing system for medicines management.	**Carried forward**

	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.	**to the next inspection**

5.2 Inspection findings

5.2.1 Staffing Arrangements

There was a robust system in place to ensure staff were safely recruited prior to commencing work. All staff were provided with an induction programme to prepare them for working with the patients. A range of training to help staff undertake their role was provided; records were in place to assist the Manager in monitoring who completed which training and when.

Staff working in nursing homes are required to be registered with a professional body. For nurses this is the Nursing and Midwifery Council (NMC) and for care staff this is the Northern Ireland Social Care Council (NISCC). Staff in the home were appropriately registered with systems in place to check that their registration remained live.

The staff duty rota accurately reflected the staff working in the home on a daily basis. There was enough staff to respond to the needs of the patients in a timely way and staff were satisfied with the number of staff on duty. Patients were happy with the manner in which staff attended them; they described the staff as friendly and very helpful.

Staff spoke compassionately about patients' needs and demonstrated a good understanding of patients' individual wishes and preferences.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine, wishes and preferences.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs. Care records contained good detail of the individual care each patient required and were reviewed regularly to reflect the changing needs of the patients. Where patients had expressed individual preferences these were included in the care plans. Records included any advice or recommendations made by other healthcare professionals. Daily records were kept of how each patient spent their day and the care and support provided by staff.

Arrangements were in place to identify patients who were unable to mobilise or move independently and therefore at greater risk of skin breakdown. Pressure relieving care was recorded on repositioning charts which evidenced that patients were assisted to change their position regularly. The reposition charts did not contain the identity of the staff who assisted the patient to change their position; this was identified as an area for improvement.

Patients with wounds had these clearly recorded in their care records; records also reflected the care delivered to encourage the healing of wounds.

If a patient had an accident or a fall a report was completed. The circumstances of each fall were reviewed at the time in an attempt to identify precautions to minimise the risk of further falls. Patients' next of kin and the appropriate organisations were informed of all accidents.

A number of patients had bedrails erected or alarm mats in place; whilst these types of equipment had the potential to restrict patients' freedom there was evidence that these practices were the least restrictive possible and used in the patient's best interest.

Patients' needs in relation to nutrition were being met; their weights were checked at least monthly to monitor weight loss or gain. Where required, records were kept of what residents had to eat and drink.

The Manager confirmed that patients had an annual review of their care, arranged by their care manager or Trust representative; these have recently returned to face to face meetings.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was warm, clean and fresh smelling throughout. Patients' bedrooms were personalised with items important to them and reflected their likes and interests. The passenger lift has recently been upgraded.

Fire safety measures were in place and well managed to ensure residents, staff and visitors to the home were safe. A fire risk assessment had been completed and a range of fire checks were carried out.

On arrival to the home our temperature was checked and a health declaration completed; hand sanitiser and PPE were available at the entrance to the home. Signage had been placed at the entrance to the home which provided advice and information about Covid-19.

There was an adequate supply of personal protective equipment (PPE) and no issues were raised by staff regarding the supply and availability. Staff spoken with were knowledgeable of the correct use of PPE, wore face masks and carried out hand hygiene. Air purifying units have been purchased and are use in the home during any visiting which takes place in the lounge or dining room areas.

Patients and staff participated in the regional monthly COVID 19 testing and staff continued to be tested weekly.

5.2.4 Quality of Life for Patients

Staff introduced us to patients using their preferred name. Staff offered choices to residents throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time. Each patient had their own routine and staff demonstrated a sound understanding of patients' behaviours and choices.

Arrangements were in place for patients to receive visitors; visits were planned on both an appointment and short notice basis. One patient was benefiting from the support of a care partner. Regular testing was completed with visitors as required.

One patient used expressions such as “first class” and spoke of being happy when talking about their experiences of the home and how they were treated. They were familiar with the Manager and RI and confirmed that they had regular contact with them.

Staff explained that due to the number of patients in the home and their varying abilities to engage, providing meaningful activities was a challenge. Some patients spoken with were not interested in joining activities and were content to spend the day doing their own thing such as word searches or reading the newspapers or magazines. One patient said he was content to watch the television. Arrangements were in place to support patients with their spiritual needs with local church services being streamed via the television screens. Patients spoken with valued this support with their spiritual needs.

The opinion of patients was sought by the RI during their monthly visits and comments included in the report. In one report a patient had commented that nothing was too much trouble for the staff and that they had everything they asked for.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. The Manager and RI are in the home daily and were knowledgeable of all aspects of the day to day running of the home. Staff commented positively about the management team and described them as supportive and approachable.

A system of auditing was in place to monitor the quality of care and other services provided to residents. Regular audits were completed of the environment, accidents and incidents and infection prevention and control practices including hand hygiene.

There was a system in place to manage complaints; complaints received, alongside the action taken, were recorded. Records were also maintained of compliments received about the home. In recent compliments the care in the home was described as “caring and professional”, staff were referred to as “amazing”; one relative concluded that their loved one had been very happy throughout their stay.

A monthly report was completed which provided evidence of consultation with residents, their relatives and reviewed areas of the running of the home. The reports of these visits were completed in detail; where action plans for improvement were put in place, these were followed up to ensure that the actions were addressed. The reports were available in the home for review by residents, their representatives, the Trust and RQIA if requested.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	0	5*

*The total number of areas for improvement includes four which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Theresa 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 the Care Standards for Nursing Homes (April 2015)	
Area for Improvement 1 **Ref:** Standard 29 **Stated:** First time **To be completed by:** From the date of inspection	The registered person should ensure fully complete and accurate personal medication records are maintained. Ref: 5.1
	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 2 **Ref:** Standard 29 **Stated:** First time **To be completed by:** 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. Ref: 5.1
	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 28 **Stated:** First time **To be completed by:** 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. Ref: 5.1
	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 28 **Stated:** First time **To be completed by:** From the date of inspection	The registered person shall develop and implement a robust auditing system for medicines management. Ref: 5.1
	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 5 **Ref:** Standard 4 **Stated:** First time **To be completed by:** From the date of inspection	The registered person must ensure that repositioning charts contain the identity of the staff who assist the patient to change their position on each occasion. Ref 5.2.2
	Response by registered person detailing the actions taken: The repositioning chart has been reviewed and updated to include identity of staff member who assisted the patient.

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

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