The Regulation and Quality Improvement Authority

Inspection Report

23 April 2024

Rivervale Country Private Care Home

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: Rivervale Country Private Care Home LLP **Responsible Individual:** Miss Cecelia Theresa O'Neill	**Registered Manager:** Ms Helena Margaret O'Neill **Date registered:** 1 April 2005
Person in charge at the time of inspection: Ms Helena Margaret O'Neill	**Number of registered places:** 20 This number includes a maximum of five patients in category NH-DE. The home is approved to provide care on a day basis for one person.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment PH (E) - physical disability other than sensory impairment over 65 years TI – terminally ill DE – dementia MP – mental disorder excluding learning disability or dementia MP (E) – mental disorder excluding learning disability or dementia over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 15
Brief description of the accommodation/how the service operates: Rivervale Country Private Care Home is a nursing home which is registered to provide care for up to 20 patients. 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 23 April 2024, from 10.30am to 3.00pm. This was completed by a pharmacist inspector. This inspection focused on medicines management within the home and also assessed progress with the area for improvements identified at the last medicines management inspection. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

The areas for improvement identified at the last care inspection have been carried forward and will be followed up at the next care inspection.

The outcome of this inspection concluded that robust arrangements were not in place for all aspects of medicines management. Two areas for improvement identified at the last medicines management inspection in relation to record keeping and governance have been stated for a second time and one new area for improvement has been identified in relation to the management of warfarin as detailed in the report and quality improvement plan.

Following the inspection, the findings were discussed with the RQIA Senior Pharmacist Inspector. RQIA decided that although areas for improvement were identified for a second time, patients were being administered their medicines as prescribed; therefore, a period of time would be given to implement the necessary improvements. A follow up inspection will be undertaken to determine if the necessary improvements have been implemented and sustained. Failure to implement and sustain the improvements may lead to enforcement.

RQIA would like to thank the staff for their assistance throughout the inspection.

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. The inspection was completed by examining 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. Discussions took place with 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

The inspector met with nursing staff, the manager and the responsible person.

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs.

Staff interactions with patients were warm, friendly and supportive. It was evident that they knew the patients well.

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.

Six questionnaires were returned and all gave positive feedback in relation to the management of medicines at Rivervale Country Private Care Home. Some comments included; "Excellent care from all staff" and "Family member here fore 2 years. His care has been exceptional".

5.0 The inspection

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

Areas for improvement from the last care inspection on 5 December 2023		
Action required to ensure compliance with Care Standards for Nursing Homes, December 2022		**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.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement has been stated for a second time. See Section 5.2.1.	
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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met. See Section 5.2.1	

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.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement, as written, was met. See Sections 5.2.1 & 5.2.4.	
Area for improvement 4 **Ref:** Standard 28 **Stated:** First time	The registered person shall develop and implement a robust auditing system for medicines management.	**Not met**
	Action taken as confirmed during the inspection: This area for improvement has been stated for a second time. See Section 5.2.3.	
Area for improvement 5 **Ref:** Standard 41 **Stated:** First time	The registered person shall ensure that the duty rota includes the first name and surname of all staff members.	**Carried forward to 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 6 **Ref:** Standard 46 **Stated:** First time	The registered person shall ensure the infection prevention and control deficits identified at this inspection are addressed: • Posters are laminated • Rusty hoist and torn pressure cushion are repaired/replaced.	**Carried forward to 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 may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by the GP, the 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, at medication reviews or hospital appointments.

It was identified that some records were not up to date with the most recent prescription. This could result in medicines being administered incorrectly or the wrong information being provided to another healthcare professional. It was evident that staff did not use these records as part of the administration of medicines process. An area for improvement was stated for a second time.

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. As detailed in Section 5.2.4, although patients' prescriptions/hospital discharge letters were available in the home, transcribing errors had not been identified by the person checking the transcription or through the home's internal audit processes.

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. Directions for use were clearly recorded on the personal medication records; and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain. These medicines were used infrequently and staff advised that the reason for and outcome would be recorded if they were administered.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans and pain assessments were in place and reviewed regularly.

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. A speech and language assessment report and care plan was in place. Some records of prescribing and administration needed updated to include the recommended consistency level. Nurses advised that this would be done immediately following the inspection and closely monitored through the revised audit processes.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside the recommended range. Nurses were reminded that in use insulin pen devices must be individually labelled and the date of opening recorded to facilitate audit and disposal at expiry. The manager advised that this would be addressed following the inspection and monitored through the audit process.

The management of warfarin was reviewed. Warfarin is a high risk medicine; safe systems must be in place for regular blood monitoring and receipt of warfarin dosage directions to ensure patients are administered the most recent prescribed dose. There was evidence that transcribed warfarin dosage directions had not been verified and signed by a second member of staff to ensure accuracy. In addition, obsolete warfarin dosage directions had not been cancelled and archived. This is necessary to ensure that staff do not refer to obsolete directions in error and administer an incorrect dose to the patient. There was no daily stock balance maintained to facilitate audit. An area for improvement was identified.

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

Medicine 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 area was observed to be securely locked to prevent any unauthorised access. It was tidy and organised so that medicines belonging to each patient could be easily located. The temperature of the medicine storage area was monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the safe 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.

A sample of the medicines administration records was reviewed. Most of the records were found to have been fully and accurately completed. A small number of missed signatures were brought to the attention of the manager for ongoing close monitoring. Nurses were reminded that handwritten medicine administration records must be verified and signed by two members of staff to ensure that they are accurate. 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 should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Management audited medicine administration within the home. However, it was noted that these audits were not completed regularly and the audit system did not include all aspects of medicines management (see Section 5.2.5). The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

The audits completed at the inspection indicated that the majority of medicines were being administered as prescribed.

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.

A review of systems in place to manage medicines for new patients or patients returning from hospital indicated that although a written confirmation of the patient's medicine regime was obtained at or prior to admission, the personal medicine records had not been accurately completed. As detailed in Section 5.2.1, an area for improvement was stated for a second time.

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. A robust audit system will help staff to identify medicine related incidents.

There had been no medicine related incidents reported to RQIA since the last medicines inspection. The findings of this inspection indicate that the auditing system is not robust and hence incidents may not be identified. The registered person should implement a robust audit system which covers all aspects of medicines. Learning from any errors/incidents should be actioned and shared with relevant staff. An area for improvement was stated for a second time.

In addition to the detailed feedback provided during the inspection, guidance on identifying and reporting medicine incidents and an audit tool to aid development of a robust audit system was shared with the manager following the inspection.

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 they staff are competent in managing medicines and that they are supported.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal.

It was agreed that the findings of this inspection would be discussed with staff for ongoing improvement.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes, December 2022.

	Regulations	Standards
Total number of Areas for Improvement	1	4*

* The total number of areas for improvement includes two that have been stated for a second time and two which are carried forward for review at the next inspection.

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Helena Margaret O'Neill, Registered 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 13 (4) **Stated:** First time **To be completed by:** From the date of inspection (23 April 2024)	The registered person shall ensure that the management of warfarin is reviewed to ensure that safe systems are in place. Ref: 5.2.1
	Response by registered person detailing the actions taken: The Management of Warfarin has been reviewed and a system has been put in place to ensure that any changes to Warfarin medication as communicated by their GP, is received preferably by email and if received by telephone, that two members of staff are present to witness the call. The instruction must be recorded on the revised template and signed by two staff members. All staff have been retrained in respect of the Management of Warfarin. We do not currently have any patients on this medication.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 29 **Stated:** Second time **To be completed by:** From the date of inspection (23 April 2024)	The registered person shall ensure fully complete and accurate personal medication records are maintained. Ref: 5.1, 5.2.1 & 5.2.4
	Response by registered person detailing the actions taken: All staff have received updated Medication Management Training. Updated training and Audits have been put in place to monitor that personal medication records are fully completed and maintained.
Area for improvement 2 **Ref:** Standard 28 **Stated:** Second time **To be completed by:** From the date of inspection (23 April 2024)	The registered person shall develop and implement a robust auditing system for medicines management. Ref: 5.1, 5.2.3 & 5.2.5
	Response by registered person detailing the actions taken: The current auditing system has been developed and implemented to provide a more comprehensive and robust system for medicines mangement.

Area for improvement 3 **Ref:** Standard 41 **Stated:** First time **To be completed by:** 5 December 2023	The registered person shall ensure that the duty rota includes the first name and surname of all staff members.
	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 46 **Stated:** First time **To be completed by:** 31 December 2023	The registered person shall ensure the infection prevention and control deficits identified at this inspection are addressed: • Posters are laminated • Rusty hoist and torn pressure cushion are repaired/replaced.
	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

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