The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Cherryvalley Care Home

Provider: Beaumont Care Homes Limited

Date of Inspection: 27 February 2025

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:	Beaumont Care Homes Limited
Responsible Individual:	Mrs Ruth Burrows
Registered Manager:	Mrs Tanya Brannigan

This home is a registered nursing home which provides general nursing care for up to 46 patients, including patients with a terminal illness. Cherryvalley Care Home also provides care for patients living with a physical disability other than sensory impairment over and under the age of 65 years.

Patients' bedrooms are located over the ground and first floors. There are communal lounges, a dining room, and garden space.

2.0 Inspection summary

An unannounced inspection took place on 27 February 2025 from 09.40 am to 4.35 pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified by RQIA, during the last inspection on 24 September 2024 by a care inspector, and on 1 October 2024 by two pharmacist inspectors; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

Evidence of good practice was found throughout the inspection in relation to management of the environment and infection prevention and control. There were examples of good practice found in relation to the culture and ethos of the home in maintaining the dignity and privacy of patients and maintaining good working relationships.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

As a result of this inspection, four areas for improvement were assessed as having been addressed by the provider; one area for improvement has been stated for a second time and two areas for improvement regarding medicines management have been carried forward for

review at a future inspection. This inspection resulted in two new areas for improvement being identified.

Full details can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the 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 patient's, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients commented positively about staff. They confirmed that staff offered them choices throughout the day which included preferences for what clothes they wanted to wear and where and how they wished to spend their time. They told us that they could have a lie in or stay up late to watch TV if they wished and they were given the choice of where to sit and where to take their meals; some patients preferred to spend most of the time in their room and staff were observed supporting patients to make these choices.

Patients spoken with said, "The staff are kind and helpful and I'm very well looked after" and "I had an issue that I spoke with the manager about. It was sorted out straight away. I have great faith in the manager and know that any concerns raised will be addressed promptly".

Following the inspection, we received three completed patient/patient representative questionnaires indicating they were very satisfied that the care provided was safe, effective, compassionate and well led. No staff questionnaires were received within the timescale specified.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing.

Patients told us that they felt well cared for; they enjoyed the food and that staff were nice. They said that the manager and staff are approachable and they felt if they had any issues that they could discuss them and were confident any concerns would be addressed accordingly.

Staff spoken with said there was good teamwork and that they felt supported in their role. Staff also said that, whilst they were kept busy, staffing levels were satisfactory apart from when there was an unavoidable absence. Patient call systems were noted to be answered promptly by staff.

Staff told us they were aware of individual patient's wishes, likes and dislikes. It was observed that staff responded to requests for assistance promptly in an unhurried, caring and compassionate manner. Patients were given choice, privacy, dignity and respect.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss patients' care, to ensure good communication across the team about any changes in patients' needs. Staff were knowledgeable about individual patient's needs, their daily routine, wishes and preferences; and were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known.

It was observed that staff respected patients' privacy and dignity by offering personal care to patients discreetly and discussing patients' care in a confidential manner. Staff were also observed offering patients choice on how and where they spent their day or how they wanted to engage socially with others.

Discussion with patients and staff evidenced that arrangements were in place to meet patients' social, religious and spiritual needs within the home. The programme of activities was displayed on the noticeboard, advising patients of forthcoming events. Patients told us that they were aware of the activities provided in the home and that they were offered the choice of whether to join in or not.

Patients were observed to enjoy a game of bingo with staff in the dining room after lunch.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse 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 and included any advice or recommendations made by other healthcare professionals.

Systems and pathways were in place to manage a decline in patients' general health in order to obtain timely advice, treatment and support from relevant health professionals and services.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

Care plans were in place to direct staff on patients' assessed oral hygiene requirements. However, a review of supplementary records evidenced that oral care was not being offered to patients twice daily as care plans stated. Records showed that oral care was offered only once in the morning. If a patient declined assistance with oral care, this was recorded and signed by two staff. This area for improvement has been partially met and is stated for a second time.

Examination of care records and discussion with staff confirmed that wound care and catheter care were well managed and referrals were made to other healthcare professionals as needed.

Review of a selection of repositioning charts for patients who require assistance by staff to change position every two hours, identified gaps in recording the delivery of care. An area for improvement was identified.

3.3.4 Quality and Management of Patients' Environment

The home was clean, tidy and well maintained. Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable. A variety of methods was used to promote orientation. There were clocks and photographs throughout the home to remind patients of the date, time and place.

Equipment used by patients such as hoists, shower chairs and wheelchairs were noted to be effectively cleaned.

Treatment rooms and sluice rooms were observed to be appropriately locked.

Fire safety measures were in place to ensure patients, staff and visitors to the home were safe. Corridors and fire exits were clear from clutter and obstruction.

Personal protective equipment, for example, face masks, gloves and aprons were available throughout the home. Dispensers containing hand sanitiser were seen to be full and in good working order. Staff members were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Mrs Tanya Brannigan has been the manager in this home since 19 March 2024. The manager was not on duty on the day of inspection.

Patients and staff commented positively about the manager and described her as supportive, approachable and able to provide guidance. Staff confirmed that there were good working relationships.

It was established that the manager has a system in place to monitor accidents and incidents which occur within the home. However, review of these records highlighted that these had not been consistently reported to RQIA in a timely manner in keeping with Regulation. An area for improvement was identified.

Review of a sample of records evidenced that the manager had processes in place to monitor the quality of care and other services provided to patients. There was evidence that the manager responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and the quality of services provided by the home.

Patients said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

Cards and letters of compliment and thanks were received by the home. Comments were shared with staff. This is good practice.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with Regulations and Standards.

	Regulations	Standards
Total number of Areas for Improvement	2*	3*

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

Areas for improvement and details of the Quality Improvement Plan were discussed with Ms Judy Derby, Operations Manager, at the conclusion of the inspection, and Mrs Tanya Brannigan, Registered Manager, post inspection, 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 Homes Regulations (Northern Ireland) 2005

Area for Improvement 1 **Ref:** Regulation 13 (4) **Stated:** Second time **To be completed by:** Ongoing from the date of inspection (24 September & 1 October 2024)	The Registered Person shall ensure that medicines are administered at their prescribed time and medication administration records accurately maintained. Ref: 2.0 **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.**
Area for improvement 2 **Ref**: Regulation 30 **Stated:** First time **To be completed:** From the date of inspection. 27 February 2025	The registered person shall ensure that RQIA is made aware of any notifiable event without delay. Ref: 3.3.5 **Response by registered person detailing the actions taken**: The Registered Manager receives notifications via email from the Home's incident platform to alert her an incident has occurred; incidents are also recorded on 24hr Shift Report which Manager receives daily. The Registered Manager will review emails and the Shift Report each morning during the week and on Monday mornings after each weekend and Reg 30 reports will be completed for any incidents that are reportable to RQIA as per guidance. The Deputy Manager will review the Shift Reports and complete Reg 30's in Home Manager's absence. Compliance will be monitored by Operations Manager during Reg 29 visits.

Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)

Area for Improvement 1 **Ref:** Standard 28 **Stated:** First time **To be completed by:** Ongoing from the date of inspection (24 September & 1 October 2024)	The Registered Person shall review the medicines ordering process to ensure only medicines which are required are ordered and stock levels are maintained to an appropriate level. Ref: 2.0 **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 21.5 **Stated:** Second time **To be completed by:** From the date of inspection. 27 February 2025	The Registered Person shall ensure that oral care is provided in line with best practice and that the rationale for any variation from best practice is clearly documented. Ref: 2.0 & 3.3.3 **Response by registered person detailing the actions taken:** The Registered Manager has reviewed the oral hygiene documentation which is now retained in a separate polypocket of each resident's supplementary documentation folders to ensure staff can reference it easily. Flash meetings occur daily at 14.30hrs, and the subject of oral hygiene and record keeping has been added to the meeting format to be discussed. The Registered Manager/Deputy Manager will have oversight by spot checking supplementary charts, including oral hygiene records. Compliance will also be spot checked by Operations Manager during Reg 29 visits
Area for Improvement 3 **Ref**: Standard 4.9 **Stated:** First time **To be completed:** From the date of inspection. 27 February 2025	The registered person shall ensure that supplementary care records, specifically, repositioning records are completed in a comprehensive, accurate and contemporaneous manner in accordance with legislative and best practice guidance. Ref: 3.3.3 **Response by registered person detailing the actions taken:** There is an allocation sheet in place for each floor which informs staff which resident they are responsible for, for that day. This includes ensuring that the allocated residents individual supplementary care charts are kept up to date. Staff are responsible for ensuring all entries of care have been recorded accurately and comprehensively. All resident's care plans have been reviewed and updated to reflect their recommended and preferred repositioning regime, particularly during the night. Each allocated staff member has a separate sheet to sign prior to the daily flash meeting and at end of each shift which confirms all records have been completed. The Registered Manager/Deputy Manager will complete spot checks when walking around Home to ensure repositioning records have been fully completed as per resident's care plan. Compliance will also be spot checked by Operations Manager during Reg 29 visits.

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

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