The Regulation and Quality Improvement Authority

Inspection Report

23 & 29 April 2024

Three Rivers Care Centre

Type of service: Nursing
Address: 11 Millbank Lane, Lisnamallard, Omagh, BT79 7YD
Telephone number: 028 8225 8227

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: Zest Investment (Omagh) Limited **Responsible Individual:** Mr Philip Scott	**Registered Manager:** Mrs Bernie McDaniel **Date registered:** Acting capacity
Person in charge at the time of inspection: Mrs Bernie McDaniel	**Number of registered places:** 70 A maximum of 20 patients in category NH-I accommodated in the Strule unit. A maximum of 22 patients in category NH-DE accommodated in the Camowen unit. A maximum of 28 patients in category NH-I accommodated in the Drumragh unit. One named patient in category NH-PE (E) to be accommodated within the Drumragh unit.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 41
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 70 patients. The home is divided in two units over two floors.	

2.0 Inspection summary

This unannounced inspection took place on 23 April 2024, from 9.30am to 3.40pm by a care inspector and on 29 April 2024, from 10.15am to 2.15pm by a pharmacist inspector.

The inspection assessed progress with all areas for improvement identified in the home 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.

There was safe, effective and compassionate care delivered in the home and the home was well led by the Manager.

Staff were seen to promote the dignity and well-being of patients and provided care in a compassionate manner.

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.

One area of improvement was identified during this inspection. This was in relation to the use of a designated room not being in accordance with its registration.

RQIA were assured that the delivery of care and service provided in Three Rivers Care Centre was safe, effective, compassionate and that the home was well led.

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 patients, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give patients 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.

The daily life within the home was observed and how staff went about their work.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with the management team at the conclusion of the inspection.

4.0 What people told us about the service

Patients said that they were very happy with the care in the home, that staff were kind and attentive and that they enjoyed the meals. One patient made the following comment: "The staff and Bernie (the Manager) are absolutely brilliant. I couldn't be cared for any better."

Patients who could not articulate their views were presented as comfortable, content and at ease in their environment and interactions with staff.

Staff spoke positively about their roles and duties, the provision of care, staffing levels, teamwork, training and managerial support.

Feedback from one returned questionnaire was all positive.

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 8 January 2024		
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 14 (26) **Stated:** First time	The registered person shall ensure that an inventory of property belonging to each patient is maintained throughout their stay in the home. The inventory record is reconciled at least quarterly. The record is signed by the staff member undertaking the reconciliation and countersigned by a senior member of staff.	**Met**
	Action taken as confirmed during the inspection: This record has been put in place.	
Area for improvement 2 **Ref:** Standard 16 (11) **Stated:** First time	The registered person shall ensure in the record of complaints it is recorded whether or not the complainant was satisfied with the outcome.	**Met**
	Action taken as confirmed during the inspection: The record of complaints has been reviewed and updated accordingly.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. A review of two staff members' recruitment records confirmed there was a robust system in place to ensure staff were recruited correctly to protect patients.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the nurse in charge when the Manager was not on duty.

Any nurse who has responsibility of being in charge of the home in the absence of the Manager has a competency and capability assessment in place. One nurse's competency and capability assessment was outstanding to be completed. Good assurances were received from the Manager to confirm that this would be acted upon with delay.

Staff registrations with the Nursing & Midwifery Council (NMC) or the Northern Ireland Social Care Council (NISCC) were audited on a monthly basis. A review of these audits found these to be appropriately maintained.

Staff said there was good team work and that they felt well supported in their role, were satisfied with communication between staff and management and they worked well as a team. The Manager explained how the number of staff on duty was regularly reviewed to ensure the needs of the patients were met.

It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way; and to provide patients with a choice on how they wished to spend their day.

There were systems in place to ensure staff were trained and supported to do their job. Staff mandatory training was maintained on an up-to-date basis. Staff spoke positively on their training and how it was provided.

5.2.2 Care Delivery and Record Keeping

Staff interactions with patients were observed to be polite, friendly and warm. It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering and discretion when assisting in personal care. Expressions of consent were evident with statements such as "Are you okay with…" or "Would you like to …" when dealing with care delivery. Staff showed understanding and sensitivity to patients' needs.

Care records were maintained which reflected the needs of the patients.

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; and included any advice or recommendations made by other healthcare professionals.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The food was attractively presented and portions were generous. There was a variety of drinks available. During the dining experience, staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed. One patient said; “The food is very good. Always plenty to eat.”

There was evidence that patients’ weights were checked at least monthly to monitor weight loss or gain. Records were kept of what patients had to eat and drink daily. Patients who had specialist diets as prescribed by the Speech and Language Therapist (SALT) had care plans in place which were in accordance with their SALT assessment. Staff had received training in dysphasia.

Patients who are less able to mobilise require special attention to their skin care. These patients were assisted by staff to change their position regularly. Care records accurately reflected the patients’ needs and if required nursing staff consulted the Tissue Viability Specialist Nurse (TVN) and followed the recommendations they made.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, alarm mats and bed rails. It was established that safe systems were in place to manage this aspect of care.

Examination of records and discussion with staff confirmed that the risk of falling and falls were suitably managed. There was evidence of appropriate onward referral as a result of the post falls review.

Daily progress records were kept of how each patient spent their day and the care and support provided by staff. Any issues of assessed need had a recorded statement of care / treatment given with effect of same recorded. The outcomes of visits from any healthcare professional were also recorded.

Care records were held confidentially.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was clean, tidy and fresh smelling throughout, with a good standard of décor and furnishings being maintained. Patients’ bedrooms were personalised with items important to the patient. Communal areas were suitably furnished and comfortable. Bathrooms and toilets were clean and hygienic.

The catering and laundry departments were tidy, clean and well organised.

Cleaning chemicals were stored safely and securely.

Inappropriate storage was being used in a designated smoking lounge, which was not being used for this purpose. An area of improvement has been made in respect of this.

The grounds of the home were suitably maintained.

All staff were in receipt of up-to-date training in fire safety. Fire safety records were appropriately maintained with up-to-date fire safety checks of the environment and fire safety drills.

The home's most recent fire safety risk assessment dated 25 July 2023 had corresponding evidence recorded of actions taken in response to the 11 recommendations made as a result of it.

Fire safety exits were free from obstruction.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control measures and the use of PPE had been provided. Staff were also seen to adhere to correct IPC protocols.

5.2.4 Quality of Life for Patients

Patients said that they were happy with their life in the home, and the care and that staff were kind and attentive. Patients were dressed well and their aids and appliances were clean.

Observations of care practices confirmed that patients were able to choose how they spent their day. The genre of music and television channels played were in keeping with patients' age group and tastes.

It was also observed that staff offered choices to patients throughout the day which included preferences for food and drink options.

The atmosphere in the home was relaxed with patients seen to be comfortable, content and at ease in their environment and interactions with staff.

The records of patient activities were well maintained.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs. Bernie McDaniel is the Manager of the home and is in the process to being registered with RQIA. Staff spoke positively about the managerial arrangements in the home, saying there was good support and availability.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The Manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults. The safeguarding policy was up-to-date and in accordance with legislation. Discussions with staff confirmed knowledge and understanding of the safeguarding policy and procedure. Staff also said that they felt confident about raising any issues of concern to management and felt these would be addressed appropriately.

It was established that the Manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to the patient's next of kin, their aligned named worker and RQIA.

Expressions of dissatisfaction were well recorded and had evidence that such expressions were taken serious and managed appropriately.

There was a wide range of audits and quality assurance in place. These audits included; care records, infection prevention and control, mealtime experience and wound care audits. These audits had action plans in place for any issues identified with name of person(s) responsible and timescales for completion.

The home was visited each month by a representative of the responsible individual to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail, with action plans in place for any issues identified. These reports are available for review by patients, their representatives, the Trust and RQIA.

5.2.6 Medicines Management

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.

The personal medication records reviewed at the inspection were accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to state that they were accurate.

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. Records included the reason for and outcome of each administration.

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 and nutritional supplements were reviewed. A speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Records of the training were available for inspection.

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 too low.

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 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. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately.

Satisfactory arrangements were in place for the safe disposal of medicines.

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. The records were found to have been fully and accurately completed.

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.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plans. Written consent and care plans were in place when this practice occurred.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. 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 medicines were being administered as prescribed.

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 records indicated that satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. Written confirmation of the patient's medicine regime was obtained at or prior to admission and details shared with the community pharmacy. The medicine records had been accurately completed.

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.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

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 the staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Medicines management policies and procedures were in place.

6.0 Quality Improvement Plan/Areas for Improvement

One area of improvement has been identified were action is required to ensure compliance with the Care Standards for Nursing Homes (December 2022).

	Regulations	Standards
Total number of Areas for Improvement	0	1

The one area of improvement and details of the Quality Improvement Plan was discussed with Mrs Bernie McDaniel, 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 Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 44 (3) **Stated:** First time **To be completed by:** 23 May 2024	The registered person shall ensure the identified room is used for the purpose of its registration or if necessary submit a variation for approval by RQIA. Ref: 5.2.3
	Response by registered person detailing the actions taken: The SMOKING LOUNGE has temporarily been used for equipment storage as there are not any residents who smoke currently or indeed since the opening of the Camowen unit to use same. The equipment has been relocated to avoid further variation.

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

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