The Regulation and Quality Improvement Authority

Inspection Report

13 March 2023

Ardmaine Care Home

Type of Service: Nursing Home
Address: 8 Fullerton Road, Newry, BT34 2AY
Tel no: 028 3026 2075

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: Healthcare Ireland (Belfast) Limited **Responsible Individual:** Ms Amanda Mitchell	**Registered Manager:** Mrs Florentina Moca **Date registered:** 21 October 2021
Person in charge at the time of inspection: Mrs Florentina Moca	**Number of registered places:** 65 Maximum of 38 patients in Category NH-DE, Dementia Unit only; Maximum of 8 patients category NH-MP.
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.	**Number of patients accommodated in the nursing home on the day of this inspection:** 56
Brief description of the accommodation/how the service operates: This is a registered nursing home which provides nursing care for up to 65 patients. Patients who have a dementia are accommodated in the Bronte Unit on the ground floor and general nursing care is provided in the Mourne Unit on the first floor. Patients have access to communal lounges, dining rooms and a garden space.	

2.0 Inspection summary

An unannounced inspection took place on 13 March 2023 from 9.15am to 5.15pm by a care 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.

Staff provided care in a compassionate manner and were well trained to provide safe and effective care. Patients spoke positively on the care that they received and on their interactions with the staff. Comments received from patients and staff members are included in the main body of this report.

One area for improvement was identified in relation to the completion and monitoring of supplementary care records.

RQIA were assured that the delivery of care and service provided in Ardmaine Nursing Home was safe, effective and compassionate and that the home was well led.

The findings of this report will provide the manager and management team with the necessary information to improve staff practice and the patients' experience.

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 manager and regional manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with eight patients, eight staff and one relative. Patients were well presented in their appearance and appeared relaxed and comfortable in their surroundings. Patients told us that they were happy living in the home. The relative consulted was very positive in relation to the care provided to their loved one. Staff members were confident that they worked well together and enjoyed working in the home and interacting with the patients.

There were 10 questionnaire responses received from patients. All respondents indicated that they felt safe, the staff were kind, the care was good and the home was well organised. Respondents provided comments, such as, "I am really happy here", "I enjoy being here", and, "I have lots of fun in the lounge". We received no feedback from the staff online survey.

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 19 & 24 August 2021		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 14.1 **Stated:** First time	The registered person shall ensure that the policies and procedures are updated to include the procedure for safeguarding patients' valuables transferred to head office. Evidence that the arrangement for transferring deceased patients' valuables to head office was agreed with the Health and Social Care Trust should be forwarded to RQIA. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met.	**Met**
Area for improvement 2 **Ref:** Standard 2.9 **Stated:** First time	The registered person shall ensure that charges for fees are levied in accordance with current Department of Health's guidelines on the care assessment process. Confirmation from the Health and Social Care Trust that it was in agreement with the recent increase to the third party contribution should be forwarded to RQIA. **Action taken as confirmed during the inspection**: There was evidence that this area for improvement was met.	**Met**

5.2 Inspection findings

5.2.1 Staffing Arrangements

Staff members were recruited safely ensuring all pre-employment checks had been completed and verified prior to the staff member commencing in post. Newly employed staff had protected time in which to complete an induction where they would work alongside a more senior member of staff to become more familiar with the home's policies and procedures. Completed induction booklets had been signed and dated by the inductor and the inductee. Agency staff were also inducted on their first shift working in the home. Copies of agency inductions were kept with the agency staff member's profile. Checks were made to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

A system was in place to monitor staffs' compliance with mandatory training. A recent monthly monitoring report indicated that the staff compliance rate was at 96.4 percent. Training was completed on a range of topics such as adult safeguarding, infection prevention and control (IPC), patient moving and handling and fire safety. An in-house staff member was trained to provide practical moving and handling training. Staff confirmed that they were happy with the training provision and that they could request additional training, pertinent to their role, if they identified this need.

Staff confirmed that they were further supported through staff supervision and appraisals. A matrix was in place to ensure all staff received, at minimum, two recorded supervisions and an appraisal on an annual basis.

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Staff consulted confirmed they were satisfied that patients' needs were met with the staffing levels and skill mix on duty. Observation of staffs' practices and discussions with patients raised no concerns in relation to the staffing arrangements in the home.

The staff duty rotas accurately reflected all of the staff working in the home on a daily basis and the designation in which they worked. The duty rota identified the nurse in charge of the home when the manager was not on duty. Nurses given the responsibility for taking charge of the home first completed a competency and capability assessment prior to taking charge. A nurse in charge file had been created to aid in this role and included the senior manager on call rota to identify which senior manager was on call and their contact details.

Staff spoke positively on the teamwork in the home. One told us, "There is good teamwork and we communicate well together," and another commented, "We have a good mix of staff here."

Patients consulted spoke highly on the care that they received and confirmed that staff attended to them when they needed them and that they would have no issues on raising any concerns that they may have to staff.

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 members were knowledgeable of patients' needs, their daily routine, wishes and preferences. A diary was maintained to ensure important daily activities were not missed such as blood tests or appointments. Staff confirmed the importance of keeping one another up to date with any changing needs in patients' care throughout the day.

It was observed that staff provided care in a caring and compassionate manner. Patients were well presented in their appearance and told us that they were happy living in the home. It was clear through patient and staff interactions that they knew one another well and were comfortable in each other's company. The relative consulted described the care in the home as, 'Very good' and complimented the staff.

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. Post admission care tracking audits were completed after the first week in the home to ensure that all the correct documentation was in place. This is a good practice. Patients' care records were held confidentially.

All patients had a pressure management risk assessment completed monthly. Where a risk of skin breakdown was identified; a care plan was developed to guide staff in how to manage this risk. Where a patient had a wound, a care plan was in place to guide staff on how to manage the wound and evaluation records monitored the progress of the care delivery. Body maps and wound photographs were in place to allow for a visual reference to the wound management.

An accident/incident form was completed by staff to record any accidents or incidents which occurred in the home. Falls safety calendars were utilised to record the incidences of falls each month. Falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, bed rails or alarm mats. It was established that safe systems were in place to manage this aspect of care. When bedrails were in use, a record of bedrail checks was maintained. It was good to note that the entries made were time specific relating to the actual time the checks were made.

Supplementary care records were completed to evidence care provision on a daily basis. While many of these had been completed well, some significant gaps were identified within some repositioning and bowel management records. An area for improvement was identified to ensure accurate completion and oversight of the supplementary care records.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this could include simple encouragement through to full assistance from staff. Staff assisted patients throughout the day with food and fluids in an unhurried manner. Nutritional risk assessments were carried out regularly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST). Staff consulted were aware of the actions to take should a patient's nutritional requirements change during the day.

Patients dined in their preferred dining area; the dining room, lounge or their own bedrooms. Tables in the dining room had been attractively set for the meal. Food was prepared in the home's kitchen then transferred in a Bain Marie to the dining area. Modified meals were pre-plated in the kitchen in accordance with the patients' choice of meal. Food served appeared appetising and nutritious. Staff maintained a list to ensure that all patients received their meals. The menu offered patients a choice of meals and the mealtime was well supervised. Staff wore personal protective equipment (PPE) and patients, who required, wore clothing protectors to maintain their dignity. Staff sat alongside patients when providing assistance with their meals. A range of drinks were served with the meals. There was a calm atmosphere at mealtime. One patient told us, "The food is never-ending but always very good".

Patients' individual likes and preferences were reflected throughout the records. Daily records were kept of how each patient spent their day and the care and support provided by staff.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. Appropriate doors leading to rooms which contained hazards to patients had been locked. The home was warm, clean and comfortable. There were no malodours detected in the home.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated and suitably furnished. Patients could choose where to spend their day in the home and staff were observed supporting patients to make these choices.

Systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. All visitors to the home were required to wear face coverings. Environmental infection prevention and control audits had been conducted monthly. Additional commode cleaning audits were completed. There were three domestics on duty each day and records were maintained of general cleaning and deep cleaning of rooms and areas within the home.

Review of records, observation of practice and discussion with staff confirmed that effective training on IPC measures and the use of PPE had been provided. Signage promoting effective hand hygiene and safe use of PPE was displayed throughout the home. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

5.2.4 Quality of Life for Patients

Patients confirmed that they received choices throughout the day. One told us, "The girls are absolutely fantastic; they would do anything for you". Another told us, "The staff are lovely, I do what I want during the day".

An activity therapist oversaw the activity provision in the home. Activities were conducted on a group and on a one to one basis and included chatting, arts and crafts, yoga, baking and gardening. An activity planner was available for review. Activities were generally held in the Bronte Suite during the morning and in the Mourne Suite in the afternoon. Special days such as birthdays, St Patrick's day and Easter were celebrated. International ladies' day had been celebrated the week previous to the inspection. Patients were observed making St Patrick's day decorations during the inspection and entertainment had been arranged for the day. Individual activity participation records were maintained for each patient in the home. Each patient had a 'my life story' completed and an activity care plan in place. Activity care plans were reviewed regularly.

Patient / relative and staff surveys had been, or were in the process of being, completed. The manager confirmed that the results of the surveys would form part of the Annual Quality Report for the home.

An email group had been set up for all next of kin to aid in communication to patients' families. A relatives' meeting had taken place during November 2022.

Visiting arrangements were in place with positive benefits to the physical and mental wellbeing of patients. Visiting was conducted in line with Department of Health guidelines. Patients were also free to leave the home with family members when they wished.

5.2.5 Management and Governance Arrangements

Since the last inspection there had been no change in the management arrangements. Mrs Florentina Moca has been Registered Manager of the home since 21 October 2021. Discussion with the manager and staff confirmed that there were good working relationships between staff and the home's management team. Staff told us that they found the manager and the management team to be 'approachable' and 'would listen to any concerns'.

Staff were aware of who the person in charge of the home was in the manager's absence. Staff told us that they were aware of their own role in the home and how to raise any concerns or worries about patients' safety, care practices or the environment. Staff members were aware of who to report their concerns to and who to escalate their concern to if they felt that this was required. Staff demonstrated good knowledge of the organisational structure in the home.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. Areas audited included patients' care records, wound care, medicines management, restrictive practice, staff training and professional registration checks.

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 patients' next of kin, their care manager and to RQIA.

A complaint's file was maintained to detail the nature of any complaints and the corresponding actions made in response to any complaints. There were no recent or ongoing complaints relating to the home. We discussed that any area of dissatisfaction brought to staffs' or management attention should be recorded as a complaint. Cards and letters of compliments were maintained in a compliments file. The manager confirmed that all compliments received would be shared with the staff.

The home was visited each month by a representative of the registered provider 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; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. There was evidence that the manager also amended action plans when the actions had been finalised. Completed reports were available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005.

	Regulations	Standards
Total number of Areas for Improvement	1	0

Areas for improvement and details of the Quality Improvement Plan were discussed with Florentina Moca, Registered Manager and Cherith Rogers, Regional Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

<table>
<tr><th colspan="2">Quality Improvement Plan</th></tr>
<tr><td colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</td></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 12 (1) (a) and (b)

Stated: First time

To be completed by:
13 June 2023</td><td>The registered person shall ensure that contemporaneous records of supplementary care provided are recorded accurately and, where appropriate, are reviewed by registered nurses when completing daily evaluations of patients.

Any actions taken as a result of review should be clearly documented within the evaluation notes.

Ref: 5.2.2</td></tr>
<tr><td>Response by registered person detailing the actions taken:
Staff has been reminded the importance of supplementary care records and appropriate documentation in accordance with legislative and best practice guidance, via supervision. A daily care needs records audit has been implemented and supplementary care records are reviewed by day and night Nurses and also through a number of means such as Daily walk about, Reg 29 visit and any actions identified adressed at time. Nursing staff has been reminded of their responsibilities on this area and the importance of a clear documentation within the daily progress notes and evaluation notes.</td></tr>
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