

Inspection Report

16 and 17 October 2023



Ardmaine Care Home

Type of Service: Nursing Home
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Assurance, Challenge and Improvement in Health and Social Care

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1.0 Service information

Organisation/Registered Provider: Healthcare Ireland (Belfast) Limited	Registered Manager: Mrs Florentina Moca
Responsible Individual: Ms Amanda Mitchell	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: 54
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 16 October 2023 from 9.30am to 4.40pm and on 17 October 2023 from 9.40am to 1.30pm 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.

Patients were well presented in their appearance and spoke positively when describing their experiences of living in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients, relatives and staff are included in the main body of this report.

Staff promoted the dignity and well-being of patients and were knowledgeable and well trained to deliver safe and effective care. There was a good working relationship between staff and management.

Areas for improvement were identified in relation to supplementary record keeping and training on first aid. RQIA were assured that the delivery of care and service provided in Ardmaine Care Home was safe, effective and compassionate and that the home was well led. Addressing the areas for improvement will further enhance the quality of care and services provided.

The findings of this report will provide the manager 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 at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with patients, relatives, staff and a visiting professional. Patients spoke positively on the care that they received and on their interactions with staff. One told us, "I am very happy here; it is a good place. The staff are very nice". Another commented, "This is a wonderful home; the staff go out of their way to help you". Staff were confident that they worked well together and enjoyed working in the home and interacting with the patients. The relatives consulted were positive on their feedback of the care provided to their loved one. The visiting professional complimented the staff.

There were no questionnaire responses received from patients or relatives and 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 13 March 2023		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		Validation of compliance
Area for improvement 1 Ref: Regulation 12 (1) (a) and (b) Stated: First time	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.	Partially met
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was not fully met and this will be discussed further in Section 5.2.2. This area for improvement has not been fully met and has been stated for a second time.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

Staff were recruited safely ensuring all pre-employment checks had been completed and verified prior to the staff member commencing in post. Recruitment was audited to ensure the correct process had been followed. All staff were provided with a comprehensive induction programme to prepare them for working with the patients. An induction booklet was completed to capture the topics covered during the induction.

There were systems in place to ensure staff were trained and supported to do their job. A system was in place to ensure staff completed their training and evidenced that 96.1 percent of staff had achieved compliance with this. Although, a deficit was identified in relation to the completion of first aid training. This was discussed with the manager and identified as an area for improvement. Training was completed online and face to face. Staff were trained on a range of topics including dementia awareness, aphasia, dysphagia, deprivation of liberty and adult safeguarding.

Staff confirmed that they were further supported through staff supervisions and appraisals. A system was in place to ensure that staff received, at minimum, two supervisions and an appraisal conducted annually.

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.

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Staff raised no concerns regarding the staffing levels and confirmed that patients' needs were met with the number and skill mix of staff on duty. Staff said there was good teamwork in the home. One told us, "We all get along well", and another commented, "We are like brothers and sisters here".

The staff duty rota accurately reflected all of the staff working in the home on a daily basis. This included staff allocated to provide one to one care in addition to the planned staffing. The rota identified the nurse in charge of the home in the absence of the manager. The nurse in charge completed a competency and capability assessment prior to commencing in the role.

It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through these interactions that the staff and patients knew one another well and were comfortable in each other's company.

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 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. A visiting healthcare professional confirmed that any instructions they had left in the home for staff to follow had been followed well.

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. Assessments and care plans were reviewed regularly to ensure that they were reflective of patients' needs. Patients care records were held confidentially.

Supplementary care records were maintained to record care delivery such as repositioning, food and fluid intake, continence care and personal care delivered. While the majority of these records had been completed well, gaps in care were identified and these were not always captured on the daily evaluation records of care. This was discussed with the manager and an area for improvement in this regard has been stated for a second time.

Continence assessments were completed on admission, reviewed regularly and informed continence care plans. Ways of enhancing these records were discussed with the manager. Staff were aware of their responsibilities in maintaining good continence care.

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.

An accident book was completed by staff to record any accidents or incidents which occurred in the home. A review of accident records following a fall in the home confirmed that the correct actions were taken following the accident and the appropriate persons notified of the fall. A fall's calendar was utilised to capture the incidences of falls in the home.

Personal care delivery had been recorded well. Individual aspects of assistance provided with personal hygiene had been recorded. Staff were aware of the actions to take should a patient refuse assistance with personal care needs. All patients were observed to be well presented in their appearance during the inspection. A relative told us, "The staff are all very attentive; they go that extra mile. It's all of the wee things that they do that are very important".

Moving and handling risk assessments and mobility care plans had been completed to ensure safe practice in this aspect of care. Handover sheets included each patient's level of assistance required.

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. Staff were knowledgeable in regards to patients' nutritional requirements. Records of patients' intake and outputs were recorded where this was required.

There was good availability of food and fluids observed during the inspection. The meal timings were adequately spaced out. Nutritional risk assessments were carried out monthly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST). Eating and drinking care plans were reflective of the recommendations from the speech and language therapist where this was relevant.

Staff wore the appropriate personal protective equipment (PPE) when serving and assisting with meals. Menus were on tables and patients had a choice of two meals. The food served appeared nutritious and appetising. A range of drinks was served with the meal. Staff sat alongside patients when providing assistance with their meals. There was a calm atmosphere in the dining room and patients spoke positively on the mealtime experience.

The manager confirmed that they had recently implemented a 'Safe Care Huddle' where staff would meet and review a daily focus on areas of care such as dehydration, oral care, falls prevention, nail care and/or infection prevention and control (IPC).

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. Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were decorated and suitably furnished. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices. The home was warm, clean and comfortable. There were no malodours in the home.

Fire safety measures were in place to ensure the safety of patients, visitors and staff. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible. Fire warden training had been arranged and face to face fire safety training from the Northern Ireland Fire and Rescue Service had been scheduled. Records of fire drills conducted in the home had been maintained and evidenced that all staff had taken part in a fire drill during 2023.

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. There were good stocks and supplies of PPE and hand hygiene products. Infection control audits had been conducted monthly. In addition, commode cleaning audits were completed regularly to ensure cleanliness.

5.2.4 Quality of Life for Patients

An activities therapist was employed to oversee activity provision in the home. A list of planned activities was available on entry to the home. Activities included fun ball games, sensory boxes, pamper sessions, movies, hairdressing, sing-a-longs, art and crafts and exercise. Activities were conducted on a group and on a one to one basis. There was an activities room on the ground floor and a cinema room and hairdressing salon located on the first floor. Several notice boards on the ground floor displayed pictures of patients engaging in activities. Individual patient's activity engagements were recorded within an activity participation file on each unit. Records included when patients were offered but did not wish to engage in the planned activity.

Patients confirmed that they were offered choice and assistance on how they spent their day. Patients confirmed that they could remain in their bedroom or go to a communal room when they requested. One patient told us, "I am quite content here. The staff are very nice and the food is good. During the day I enjoy to go for a walk or go with the girl who does the exercises". Another commented, "I enjoy reading my books in my room".

Staff provided care in a dignified manner. Personal care was delivered discreetly behind closed doors. The manager confirmed that relatives have had the opportunity to complete a survey in relation to the care and services provided in the home and that they could do this anonymously if they wished. Some of their feedback was included within a compliments file which was shared with staff.

Visiting had returned to pre-covid arrangements. Visits could take place in the patients' preferred visiting areas including their bedrooms. Patients were free to leave the home with relatives if 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 the Registered Manager of the home since 21 October 2021. Discussion with staff confirmed that there were good working relationships between staff and the home's management team. Staff confirmed that they found the manager to be 'approachable' and 'would always listen to any concerns'.

Staff told us that they were aware of their own roles 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, restrictive practice, staff training and the environment.

Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA. Falls in the home were reviewed monthly, within each unit, for patterns or trends to see if any further falls could be prevented.

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 and the reports were available for review by patients, their representatives, the Trust and RQIA. Where improvement actions were required, an action plan was included within the report. The action plan would be reviewed at the subsequent monthly monitoring visit to ensure completion.

A complaint's book was maintained and records included the nature of the complaint and any actions taken in response to the complaint. Cards and letters of compliments were maintained on file and shared with staff.

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.

	Regulations	Standards
Total number of Areas for Improvement	2*	0

*The total number of areas for improvement includes one that has been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with Florentina Moca, 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 Homes Regulations (Northern Ireland) 2005	
<p>Area for improvement 1</p> <p>Ref: Regulation 12 (1) (a) and (b)</p> <p>Stated: Second time</p> <p>To be completed by: 17 November 2023</p>	<p>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.</p> <p>Any actions taken as a result of review should be clearly documented within the evaluation notes.</p> <p>Ref: 5.1 and 5.2.2</p>
	<p>Response by registered person detailing the actions taken:</p> <p>Residents supplementary care records are completed by care staff and reviewed by Registered Nurses during their shift, the outcome of this review will be reflected in the residents daily progress notes and care plan evaluations as required. Supplementary care records continue to be reviewed as part of the Manager Walk Round and any actions identified will be addressed with relevant staff on duty. Resident care records will be reviewed during the completion of care file audits and any deficits identified will be included in an action plan including a timeframe for completion.</p>
<p>Area for improvement 2</p> <p>Ref: Regulation 14 (2)(d)</p> <p>Stated: First time</p> <p>To be completed by: 31 December 2023</p>	<p>The registered person shall ensure that staff are trained on first aid.</p> <p>Ref: 5.2.1</p>
	<p>Response by registered person detailing the actions taken:</p> <p>All staff complete First Aid training on Healthcare Irelands online platform EVO during their induction and annually thereafter. Face to face First Aid Training has been planned for 13.12.23 with further dates are to be confirmed.</p>

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