The Regulation and Quality Improvement Authority

Inspection Report

19 & 24 August 2021

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 Celine Mitchell	**Registered Manager:** Mrs Florentina Moca – not registered
Person in charge at the time of inspection: Mrs Florentina Moca	**Number of registered places:** 70 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. MP – Mental disorder excluding learning disability or dementia. DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 51
Brief description of the accommodation/how the service operates: This is a registered Nursing Home which provides nursing care for up to 70 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 19 August 2021 from 9.15am to 5.00pm by a care inspector and continued on 24 August 2021 from 11.00am to 4.00pm by a finance 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 spoke positively on 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 and staff are included in the main body of this report.

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

Staff promoted the dignity and well-being of patients and were knowledgeable and well trained to deliver safe and effective care. A new manager had commenced employment in the home with positive benefits to both patients and staff.

Review of the management of patients' finances found that improvements were needed in retaining evidence of the Health and Social Care Trust agreeing to the increase in third party payments and the transfer of personal items for deceased patients to the home's head office.

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 and 'Tell Us' cards 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.

4.0 What people told us about the service

Thirteen patients, nine staff, two visitors and one visiting health professional were consulted during the inspection. Patients spoke positively on the care that they received and with their interactions with staff describing staff as lovely and friendly. Staff were confident that they worked well together and enjoyed working in the home and interacting with the patients.

The visiting professional confirmed that they found the staff knowledgeable about the patients in their care and that staff would follow any instructions left in relation to patient care. The health professional also confirmed that staff would seek advice if they were unsure about any aspect of the recommended care.

Two visitors consulted were positive in their feedback on the care provision in the home. One described the care as 'exceptional' and the second commended the 'attention to detail' in the care provision.

Ten staff responded to the online staff survey. All respondents were either satisfied or very satisfied that the home provided safe, effective and compassionate care and that the home was well led. Four questionnaire responses from relatives were received. Relatives indicated in their responses that they were also either satisfied or very satisfied that the home delivered safe, effective and compassionate care and that the home was well led. All written responses included within the online survey and the questionnaire returns were shared with the manager for their review and actions as appropriate.

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 21 January 2021		
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015		**Validation of compliance**
Area for Improvement 1 **Ref**: Standard 4 Criteria (9) **Stated:** Second time	The registered person shall ensure that supplementary care records including repositioning charts are completed in a comprehensive, accurate and contemporaneous manner in accordance with legislative and best practice guidance.	**Met**
	Action taken as confirmed during the inspection: A review of three patients' supplementary care records evidenced that this area for improvement has now been met.	
Area for Improvement 2 **Ref**: Standard 18 **Stated:** First time	The registered person shall ensure that when a patient is subject to a restrictive practice a record is maintained of multidisciplinary involvement in the decision making process.	**Met**
	Action taken as confirmed during the inspection: A review of three patients' care records evidenced that this area for improvement has been met.	
Area for improvement 3 **Ref**: Standard 44	The registered person shall ensure that the malodour in the identified room is managed effectively.	**Met**

Criteria (1) **Stated:** First time	**Action taken as confirmed during the inspection**: The malodour in the identified room had been managed appropriately.	
Area for improvement 4 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that audit action plans created to address areas identified for improvement are reviewed to ensure completion.	**Met**
	Action taken as confirmed during the inspection: A review of auditing records evidenced that this area for improvement has been met.	

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. All staff were provided with a comprehensive induction programme to prepare them for working with the patients; this also included agency or temporary staff. 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.

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics such as infection prevention and control (IPC), patient moving and handling and fire safety. A system was in place to ensure that staff completed their training. Staff confirmed that they were further supported through staff supervisions and appraisals. A matrix was maintained to ensure that all staff received an annual appraisal and at minimum two supervisions per year.

The Manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Staff confirmed that they were very busy in the home but that patients' needs were met with the number and skill mix of staff on duty. Staff said there was good teamwork in the home.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis. This included the use of agency staff. The duty rota identified the nurse in charge when the manager was not on duty.

Patients 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. 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.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering; discussing patients' care in a confidential manner and by offering personal care to patients discreetly. This was good practice. Staff were observed to be prompt in recognising patients' needs and any early signs of distress, especially in those patients who had difficulty in making their wishes known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

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. Patients care records were held confidentially.

Patients who were less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly. A record of repositioning had been maintained and included evidence of skin checks on repositioning. Staff were aware of the actions to take when a patient was found with broken/red skin. Staff nurses confirmed that care assistants were very good at reporting any concerns that they may have to them.

Where a patient was at risk of falling, a dedicated falls care plan was in place to direct staff in how to manage this area of care. Falls in the home were monitored monthly to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to prevent further falls from occurring. Following any fall in the home a post fall review was conducted by the manager to ensure that the appropriate actions had been taken following the fall; the appropriate persons notified and the appropriate records updated. This was good practice.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, alarm mats and/or bed rails. Review of three patients' care records and discussion with the manager confirmed that the correct procedures had been followed when restrictive practices had been used.

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. Records of patients' intake and outputs were recorded where this was required. Nutritional risk assessments were carried out monthly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST).

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. 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. A fire risk assessment had been completed on 16 November 2020 and any identified actions required had been recorded as completed.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated and suitably furnished. There was evidence of recent redecoration and the managers confirmed that communal corridors had been repainted and new lighting had been installed. A plan was in place to replace the flooring in the communal corridor of the Bronte Unit. Patients could choose where to sit or where to take their meals 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. For example, the home participated in the regional testing arrangements for patients and staff. Environmental infection prevention and control audits had been conducted monthly.

All visitors to the home had a temperature check and symptom checks when they arrived at the home. They were also required to wear personal protective equipment (PPE). Visits were by appointment only.

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. In addition, equipment audits were also conducted on items such as commodes, mattresses and specialised chairs to ensure that these were maintained clean and safe for use.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV. Patients confirmed that they could remain in their bedroom or go to a communal room when they requested.

Since the last inspection, a second activities therapist had been employed. A programme of activities was on display and activities included current affairs, cinema, walks, music, quiz, reminiscence and games. The activity provision included group activities and one to one activity for those who did not wish to or could not engage in the group activities. The hairdresser had recommenced visits to the home. Patients and staff spoke fondly of a clown who entertained patients the day prior to the inspection and spoke of 'Crazy Hair Day' which was planned for the day following the inspection.

The activities coordinator spoke of planned activities designed to bring people together to assist in socialising and friendships. Each patient had an individual activity involvement record maintained to ensure that all patients who wished to could engage with activities in the home. A newsletter was in the process of being developed specifically for Ardmaine nursing home to be shared with patients and their visitors/next of kin.

Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

Since the last inspection a new manager had been employed. Mrs Florentina Moca commenced as manager of the home on 17 May 2021 and an application to register with RQIA as the manager of the home had been submitted to RQIA and was in process. The manager confirmed that she felt supported from senior management within the organisation. Staff spoke positively of the new manager describing her as approachable and always available to provide guidance and support. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

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, care practices or the environment.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. 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 patient/relative satisfaction survey had been sent out to patients' next of kin requesting feedback on the service and care provision in the home. The regional manager confirmed that once these have been returned, the results will be collated in Healthcare Ireland's Head Office and will form part of the home's Annual Quality Report.

It was noted that patients and their relatives were provided with written information on how to raise a concern or complaint about care or any service they received in the home.
A complaints file was maintained and evidenced detail of any investigations into complaints made and the corresponding actions including correspondence sent to the complainant. Learning from complaints was shared with staff through staff meetings and during planned supervision. This was good practice. Cards and compliments were kept on file and shared with staff. One such compliment email identified an 'exceptional quality of care, diligence and generosity of spirit' shown to their loved one.

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. Completed reports were available for review by patients, their representatives, the Trust and RQIA.

Review of staff training records confirmed that all staff were required to complete adult safeguarding training on an annual basis.

Staff told us they were confident about reporting any concerns about patients' safety. Staff were aware of who to report their concerns to and who to escalate their concern to if they felt that this was required.

5.2.6 Findings from finance inspection

A safe place was provided within the home for the retention of patients' monies and valuables. At the time of the inspection there were satisfactory controls around the physical location of the safe place and the members of staff with access to it. Records of monies and valuables held at the home on behalf of patients were up to date at the time of the inspection.

A review of records showed that items previously held in the safe place for discharged and deceased patients had been transferred to the home's head office. These items had been held at the home for a considerable period of time. There was no evidence that the Health and Social Care Trust (HSCT) had agreed to the transfer to head office. The transfer of the items was not in line with the policy operated at the home for retaining deceased patients' property. It was noted that these items would not be included in the records of checks of patients' valuables held at the home. This was discussed with the manager and identified as an area for improvement.

A bank account was in place to retain patients' monies. A sample of statements from the bank account was reviewed, the account only contained patients' monies and was not used for the running of the care home. A sample of withdrawals identified from the bank statements was reviewed; the amounts withdrawn reflected the amounts recorded as lodged at the care home on behalf of patients. Comfort fund monies were also held on behalf of patients, these are monies donated to the home for the benefit of all patients.

A sample of records evidenced that reconciliations (checks) of monies held on behalf of patients were undertaken on a monthly basis. Records of the reconciliations were signed by both the administrator and the manager. Records of monies held on behalf of deceased and discharged patients were not retained with the monthly reconciliation records. We were told that these records were held at head office. A record was forwarded from head office during the inspection which confirmed the amount held. The manager was advised to retain these records at the home to facilitate the audit process. Following the inspection the manager contacted RQIA to confirm that the records are now retained with the records of reconciliations. This will be reviewed at the next RQIA inspection.

It was noted that comfort fund monies were not included in the monthly reconciliation of monies and valuables held on behalf of patients. The manager was advised to include these monies in the monthly checks. Following the inspection the manager contacted RQIA to confirm that comfort fund monies were now included in the monthly checks. This procedure will be reviewed at the next RQIA inspection.

Copies of four patients' written agreements were reviewed. The agreements set out the terms and conditions for residing at the home and included the details of the current weekly fee paid by, or on behalf of, patients. A list of services provided to patients as part of their weekly fee and services available at an additional cost, such as hairdressing, was also included within the agreements. Two agreements were signed by the patients, or their representatives and a representative from the home. The remaining two agreements had yet to be signed and returned by the patients' representatives.

The manager told us that these agreements will be followed up with the patients' representatives. This will be reviewed at the next RQIA inspection.

Records of fees received on behalf of two patients were reviewed; the amounts received reflected the weekly fees listed in the patients' agreements. The manager confirmed that no patient was paying an additional amount towards their fee over and above the amount agreed with the Health and Social Care Trusts.

Review of records confirmed that a weekly third party contribution (top up) was paid on behalf of care managed patients. Records showed that the additional contribution was either paid directly to the home by the HSCT or by a third party. Discussion with staff confirmed that the third party contribution was not for any additional services provided to patients but the difference between the tariff for the care home and the regional rate paid by the Health and Social Care Trusts.

A review of a sample of records from payments received confirmed that the third party contribution had recently increased. There was no evidence to confirm that the increase had been agreed with the HSCT. This was discussed with the manager and identified as an area for improvement.

The manager told us that no member of staff was the appointee for any patient, namely a person authorised by the Department for Communities to receive and manage the social security benefits on behalf of an individual.

A sample of purchases undertaken on behalf of patients was reviewed. The records were up to date at the time of the inspection. Two signatures were recorded against each entry in the patients' records and receipts were available from each of the purchases reviewed.

A sample of records of payments to the hairdresser and podiatrist were reviewed. Records were up to date and signed by two members of staff. The manager was advised to ensure that the records were signed by the person providing the service and countersigned by a member of staff to confirm that the treatments took place. Following the inspection the manager contacted RQIA to confirm that this procedure was implemented at the home. This will be reviewed at the next RQIA inspection.

A review of a sample of records evidenced that two patients had insufficient funds to either purchase toiletries or pay for additional services, such as hairdressing. Discussion with staff confirmed that toiletries and additional services were still purchased on behalf of the patients however; the monies used to make the purchases were taken from patients who had sufficient funds. These patients were refunded once monies were received on behalf of those patients with negative balances.

The inspector highlighted that patients with available funds should not be subsidising patients with insufficient funds. Following the inspection the manager contacted RQIA to confirm that a new system was implemented to ensure that no patient was subsidising others. This procedure will be reviewed at the next RQIA inspection.

A sample of records of monies deposited at the home on behalf of patients was reviewed. Records were up to date at the time of the inspection. Receipts were provided to the person depositing the monies on behalf of the patient.

A sample of two patients' property records evidenced that the records were updated when additional items were brought into patients' rooms and when items were disposed of. The records were checked and signed by two members of staff at least quarterly.

Policies and procedures for the management and control of patients' finances were available for inspection. The policies were readily available for staff use. The policies were up to date and reviewed at least every three years.

6.0 Conclusion

Patients spoke positively on living in the home and were presented well in their appearance. Adequate staffing arrangements were in place to deliver the care required to patients. Staff had been recruited safely and trained well. The environment was warm, clean and comfortable for patients to live in. Patients could avail of any of the varied activities on offer in the home and visiting was in line with DOH guidelines. The quality of the care and service provision in the home was monitored by the manager and the management team through internal audit to ensure effectiveness in the care delivery.

Based on the inspection findings and discussions held we are satisfied that this service is providing safe and effective care in a caring and compassionate manner and that the service is well led by the manager and management team.

As a result of the finance element of the inspection, RQIA was assured that this service is providing safe and effective care in a caring and compassionate manner. However; two areas for improvement were identified in relation to the service being well led with regard to patients' finances. These areas for improvement will be reviewed at a future inspection to ensure they have been addressed.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with the Care Standards for Nursing Homes (April 2015)**.**

	Regulations	Standards
Total number of Areas for Improvement	0	2

Areas for improvement and details of the Quality Improvement Plan were discussed with Florentina Moca, Manager, and Karen Agnew, Regional 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 (April 2015).

Area for improvement 1 **Ref:** Standard 14.1 **Stated:** First time **To be completed by:** 24 September 2021	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. Ref: 5.2.6
	Response by registered person detailing the actions taken: Records are kept and maintained with regards to safeguarding of patients valuables in the home . We are awaiting confirmation from theTrust for the next of kins that have been located so the identified belongings can be returned . For those that are unable to be located or lost property the proceeds will be donated to the comfort fund.
Area for improvement 2 **Ref:** Standard 2.9 **Stated:** First time **To be completed by:** 24 September 2021	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. Ref: 5.2.6
	Response by registered person detailing the actions taken: The fees are levied in accordance with the Department of Healths guidelines. We are awaiting confirmation from the Sourthern Trust with regards to the third party contribution. This remains ongoing.

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

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