

Unannounced Care Inspection Report 9 March 2017



Ard Mhacha House Care Centre

Type of Service: Nursing Home
Address: Desart Lane South, Armagh, BT61 8AR
Tel no: 028 3752 6462
Inspector: Sharon Loane

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

1.0 Summary

An unannounced inspection of Ard Mhacha House Care Centre took place on 9 March 2017 from 10.15 to 16.50 hours.

The inspection sought to assess progress with any issues raised during and 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. The focus of the inspection was underpinned by information received by RQIA from the Southern Health and Social Care Trust as a result of an adult safeguarding investigation. This was in relation to record keeping and care delivery.

Concerns were identified during this inspection in respect of the quality of nursing care and the governance arrangements in the home. The deficits identified in both governance arrangements and care delivery had the potential to impact negatively on patient outcomes.

Is care safe?

Weaknesses were identified in the delivery of safe care, specifically in relation to medicines management and the use of restraint and restrictive practices. The shortfalls identified at this inspection had the potential to impact on the delivery of safe, effective patient care.

Is care effective?

Weaknesses were identified in the delivery of effective care specifically in relation to the management of care planning, wound care, and bowel management. Despite some of these matters having been raised previously, there was limited evidence of improvement or progress since the last care inspection. The shortfalls identified had the potential to negatively impact on patients' health and welfare.

Is care compassionate?

There was evidence of good communication in the home between staff and patients and patients were praiseworthy of staff. Staff interactions were observed to be compassionate and caring. Patients were afforded choice, privacy, dignity and respect. During the inspection, activities were provided and patients were observed participating at various levels and appeared to enjoy these.

Is the service well led?

Despite some matters being raised previously compliance was not achieved. Four requirements and one recommendation made at the previous inspection continued not to be met and have been stated for a second time.

Following this inspection, the responsible individual was required to attend a serious concerns meeting in RQIA on 20 March 2017, to discuss the findings and to provide RQIA with assurances and an action plan which illustrates how the home will return to compliance. The outcome of this meeting is detailed in section 1.1 below.

Further inspection will be undertaken to validate that compliance has been achieved. The term 'patients' is used to describe those living in Ard Mhacha House Care Centre which provides both nursing and residential care.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	7*	3*

*The total number above includes four requirements and one recommendation which have been stated for the second time.

Details of the Quality Improvement Plan (QIP) within this report were discussed with Norma McAllister, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

As a result of this inspection, RQIA were concerned that the quality of care and services within Ard Mhacha House Care Centre was below the minimum standard expected. As a consequence of the inspection findings a decision was taken to hold a serious concerns meeting. The inspection findings were communicated in correspondence to the responsible individual, Mr John Rafferty, and a meeting took place in RQIA on 20 March 2017.

The responsible individual, Mr John Rafferty and a nurse consultant to Runwood Care Homes Ltd attended the meeting. The registered manager, Norma McAllister, was unable to attend due to prior commitments.

During the meeting, management representatives acknowledged the failings identified and submitted a draft action plan to address the identified concerns. It was agreed that the action plan would be reviewed and revised to reflect the matters discussed. RQIA can confirm that the revised action plan has been received.

RQIA were satisfied with the action plan and assurances provided and a decision was made to give Runwood Homes Ltd a period of time to address the concerns raised. A further inspection will be undertaken to validate compliance and drive necessary improvements.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 13 July 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Runwood Homes Ltd/Mr John Rafferty	Registered manager: Mrs Norma McAllister
Person in charge of the home at the time of inspection: Norma McAllister	Date manager registered: 23 October 2015
Categories of care: NH-I, NH-PH(E), NH-PH, NH-DE, RC-DE A maximum of 39 patients in category NH-DE and a maximum of 15 residents in category RC-DE	Number of registered places: 74

3.0 Methods/processes

Prior to the inspection we analysed the following information:

- the registration status of the home
- written and verbal communication received by RQIA since the last care inspection
- the previous care inspection report
- the returned QIP from the previous care inspection
- notifications received since July 2016

The following methods and processes used in this inspection include the following:

- validation evidence linked to the previous QIP
- a discussion with the registered manager
- discussion with staff
- staffing arrangements in the home
- observation of care practices and care delivery
- care records & supplementary charts
- complaints received since the previous care inspection
- audits in relation to wounds/ pressure care damage and care records
- monthly quality monitoring reports in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005

During this inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. Questionnaires were distributed to patients, relatives and staff. We also met with twelve patients individually and with the majority of others in small groups. The deputy manager, three registered nurses, four care staff, two activities co-ordinators, one domestic assistant and two catering staff were also consulted.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 02 August 2016

The most recent inspection of the home was an unannounced medicines management inspection. The completed QIP was returned and approved by the pharmacy inspector.

There were no issues required to be followed up during this inspection and any action taken by the registered providers, as recorded in the QIP will be validated at the next medicines management inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 13 July 16

Last care inspection statutory requirements		Validation of compliance
Requirement 1 Ref: Regulation 12 (1) (a) (b) Stated: First time	The registered person must ensure that the treatment provided to each patient meets their individual needs and reflects current best practice. This relates specifically to the management of nutrition including weight loss, food and fluid intake and wound care.	Partially Met
	Action taken as confirmed during the inspection: A review of care records identified that this requirement had been met in regards to the management of nutrition including weight loss. Shortfalls continued to be evidenced in regards to the care and treatment delivered for wounds management. Refer to section 4.4 for further detail.	
	This requirement was partially met and has been stated for the second time.	

<p>Requirement 2</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: First time</p>	<p>The registered person must ensure that medications are administered as prescribed.</p> <p>Particular attention should focus on the prescribing and administration of nutritional supplements.</p> <hr/> <p>Action taken as confirmed during the inspection: A review of medication administration records and care records identified that patients were receiving nutritional supplements as prescribed by the general health practitioner and other health care professionals. However, the medication prescription record for one patient had not been updated to reflect recent changes. In addition, medications administered and recorded as given to an identified patient were observed sitting on a nursing table in the patients bedroom. Refer to section 4.3.</p> <p>This requirement was not met and has been stated for a second time. Refer to sections 4.3 and 4.4 for further detail.</p>	<p>Not Met</p>
<p>Requirement 3</p> <p>Ref: Regulation 16</p> <p>Stated: First time</p>	<p>The registered persons must ensure care records are kept under review and updated in accordance with changes in the patient’s condition to reflect any recommendations made and /or treatment required by the multidisciplinary team.</p> <hr/> <p>Action taken as confirmed during the inspection: A review of care records identified a lack of progress had been made in relation to the requirement made. A number of care plans and risk assessments were either not available and/or updated. This was to include recommendations made by other health care professionals. For example; recommendations made by a dietician in respect of one patient had not been reflected in the patient’s care plan.</p> <p>This requirement was not met and has been stated for the second time. Refer to section 4.4 for further detail.</p>	<p>Not Met</p>

<p>Requirement 4</p> <p>Ref: Regulation 19 (1) (a), schedule 3, (3) (k)</p> <p>Stated: First time</p>	<p>The registered person must ensure contemporaneous records of all nursing care provided to the patient, are recorded accurately, to evidence actual care and treatment given, and accounts for any concerns or deficits identified.</p> <p>Particular attention should focus on the areas identified on inspection.</p>	<p style="text-align: center;">Not Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>A review of information within care records and supplementary charts identified continued deficits in recording care delivered. These included but not limited to; wound care and bowel management.</p> <p>This requirement was not met and has been stated for a second time. Refer to section 4.4 for further detail.</p>		
<p>Requirement 5</p> <p>Ref: Regulation 13 (1)</p> <p>Stated: First time</p>	<p>The registered person must ensure that there are robust systems in place to ensure the safe and effective delivery of care to patients. This relates specifically to the management of weight loss.</p>	<p style="text-align: center;">Met</p>
<p>Action taken as confirmed during the inspection:</p> <p>There was evidence of regular monitoring of patients weights in accordance with the level of risk identified and instructions outlined in the plan of care. The registered manager advised that the home were working collaboratively with the Dietetics department at the Southern Health and Social Care Trust. A portal system had been developed for monitoring patients identified with nutritional needs.</p>		

Last care inspection recommendations		Validation of compliance
Recommendation 1 Ref: Standard 19.4 Stated: First time	<p>The registered manager should ensure that registered nurses are provided with training, as appropriate, on the care planning process. This should include risk assessments, assessments of needs, care planning, evaluations and record keeping.</p>	Not Met
	<p>Action taken as confirmed during the inspection: A discussion with the registered manager confirmed that registered nurses had been provided with training in relation to the nursing process to include care planning. However shortfalls identified in this inspection evidenced that the training delivered had not been effective and embedded into practice.</p> <p>This recommendation was not met and has been stated for a second time. Refer to section 4.4. for further details.</p>	
Recommendation 2 Ref: Standard 35.7 Stated: First time	<p>The registered person should ensure that the Regulation 29 monitoring visits include a focus on the requirements and recommendations made during this inspection. Particular attention should be given to the management of weight loss, to include food and fluid intake charts.</p>	Not Met
	<p>Action taken as confirmed during the inspection: A review of monthly monitoring reports completed for three calendar months evidenced that some of the shortfalls identified at the previous care inspection and at this inspection had either not been identified and / or followed up in a robust manner to ensure quality improvement. This subsequently resulted in some requirements and recommendations made previously having to be stated for a second time.</p> <p>This recommendation has been subsumed into a requirement made in relation to governance arrangements.</p>	

<p>Recommendation 3</p> <p>Ref: Standard 35 Criteria 17</p>	<p>The registered person should ensure that systems and processes are in place to ensure that urgent communications, safety alerts and notices are made available to key staff in a timely manner.</p>	<p>Met</p>
<p>Stated: First time</p>	<p>Action taken as confirmed during the inspection: A discussion with the registered manager confirmed that a system had been implemented to review all urgent communications, safety alerts and notices. This information is shared with staff as deemed appropriate to their roles and responsibilities.</p>	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. The registered manager advised at the beginning of the inspection that planned staffing levels were not in place at the time of the inspection, due to a staffing issue that had occurred that morning. The deputy manager who works in a supernumerary capacity was available to support staff and deliver care and cover was obtained for the shortfall identified.

A review sample of staff duty rotas evidenced that in the majority planned staffing levels were adhered to. Where a deficit in staffing was identified in advance, cover for that shift was arranged. The registered manager advised that the home were in the final stages of recruitment for registered nurses and were also actively trying to recruit for a deficit identified in relation to the role of care staff. In the interim agency staff were being as far as possible 'blocked booked' to cover shifts for both registered nurses and care staff.

Staff consulted confirmed that planned staffing levels when adhered to meet the assessed needs of the patients. Staff advised that whilst management always tried their best to cover shifts, obtaining cover at short notice proved to be difficult and that this did impact on care being delivered in a timely manner.

Observation of the delivery of care at the time of the inspection evidenced that the majority of patients' needs were met by the levels and skill mix of staff on duty. However, it was apparent that staffs ability to deliver safe effective compassionate care within one unit were impacted upon due to the staffing situation previously referred to and the enhanced levels of supervision required by an identified patient. This matter was discussed with the registered manager who advised that alternative arrangements were being put in place to ensure the needs of the patient were being met effectively. Following the inspection, the registered manager confirmed by an email correspondence that this matter had been resolved.

Discussion with patients evidenced that there were no concerns regarding staffing levels. Responses received in returned questionnaires by patients, relatives and staff indicated that they were either satisfied and/or very satisfied with the current staffing arrangements. One response received from a patient indicated that 'three care staff' should be available at all times. No other concerns were raised.

Some concerns were identified in regards to the safe administration of medicines. Medication was observed sitting on a patient’s nursing table at approximately 13.30 hours within their bedroom area. A discussion with the registered nurse confirmed that the medication had been administered and recorded as taken at the morning medication round. This practice was unsafe and posed potential risks to both the patient and other patient’s health and welfare and was not in keeping with best practice guidelines. A requirement made at a previous inspection continued not to be met. A requirement has also been made in regards to the provision of training for registered nurses in medicines management. Deficits were also identified in regards to the use of PRN (when required) medication and are discussed in section 4.4. Post inspection these findings were shared with the pharmacy inspector for further consideration and actions as deemed appropriate.

A patient observed in the general nursing unit and noted to be at high risk of falling was seated in a wheelchair for the duration of the inspection. The patient was restless and unsettled and was constantly trying to rise from their chair. On a number of occasions the seat belt on the wheelchair was observed as fastened. A review of information within the care records and discussion with staff indicated that the patient required high levels of supervision and the seat belt was fastened to maintain their safety. A risk assessment and a care plan had not been completed. Discussion with staff indicated a lack of understanding that this intervention could be considered as a form of restrictive practice and has been included in a requirement made in regards to training provision. This practice also identified a deficit in the needs of patients needs being appropriately met to ensure safe effective care. These have been referred to further in sections 4.4 and 4.6.

Areas for improvement

A requirement has been made in relation to training for staff; this includes medicines management and the use of restraint and/or restrictive practices to ensure safe practice and care delivery.

Number of requirements	1	Number of recommendations	0
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4.4 Is care effective?

As discussed in section 4.3, a review of care records including risk assessments and care plans identified that some care plans were not maintained and regularly reviewed in response to the changing needs of the patient. Risk assessments and care plans had not been completed for up to three weeks after the date of admission. Care records examined did not evidence a systematic approach to assessing, planning and evaluating care. This was concerning, as there was a lack of information to direct and inform the care required to meet patients’ health and welfare needs.

Shortfalls were identified in relation to the treatment and care delivered in regards to wound care and/or pressure care management. A review of wound care records for two identified patients evidenced gaps in the delivery of care and documentation was not in keeping with best practice guidelines. For example; wounds that required dressings to be renewed daily had not been changed on four occasions within a ten day timeframe. This was concerning given that the treatment plan advised that the dressing(s) were to be renewed daily. In addition there were inconsistencies in regards to the recording of information and wound assessment charts were not available and/or completed. These shortfalls were discussed with the registered manager as they could impact on the delivery of safe and effective care.

The shortfalls aforementioned had also been identified at a previous care inspection and it is concerning that the required improvements had not been made. Requirements made at the previous inspection have been stated for a second time.

A review of repositioning charts identified that these were not being recorded accurately, and significant gaps were noted on repositioning charts and were not in adherence with the patients care plan. A care plan reviewed in relation to pressure management for an identified patient indicated that they required two hourly positional changes; however a review sample of records evidenced gaps of up to and including nine hours between positional changes. There was no evidence that these records were being monitored and reviewed by registered nurses and corrective actions taken.

There was, therefore, potential for nursing staff to fail to prevent, identify or manage pressure care and/or pressure ulcers appropriately.

A review of bowel management records indicated a lack of oversight and monitoring. Gaps were identified and deficits had not been identified or responded to by registered nurses. The review of bowel management records for one identified patient evidenced that they had no recorded bowel function for at least eight days. It was difficult to determine the accuracy of this information as records prior to this time were unavailable and/or not completed. Furthermore, a review of additional information identified that continence assessments had not been completed to identify potential risks and direct care delivery.

As previously referred to concerns were also identified in regards to the administration of medicines, which directly impacted on bowel management and the management of distressed reactions of patients.

The concerns outlined above have been addressed both through requirements and a recommendation made.

Discussion with the registered manager and staff evidenced that nursing staff were required to attend a handover meeting at the beginning of each shift. In addition to the handover, 'flash meetings' are also held daily.

Staff spoken with stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they could raise these with their line manager and/or the registered manager.

Patients spoken with expressed their confidence in raising concerns with the home's staff/ management

Areas for improvement

Requirements have been made and/or stated for a second time in relation to patient's health and welfare, treatment provided to patients and care records. A recommendation has also been made in relation to the completion of continence assessments. A requirement has been made under the safe domain in regards to medicines management and training.

Number of requirements	1	Number of recommendations	1
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4.5 Is care compassionate?

Observations throughout the inspection evidenced that in the majority of units there was a calm yet busy atmosphere in the home and staff were attending to patients' needs. Staff spoken with were knowledgeable regarding patient's personal preferences.

Patients spoken with commented positively in regard to the care they received and were generally happy in their surroundings.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. Observations of care delivery confirmed that patients were assisted appropriately, with dignity and respect with the exception of the issues referred to in section 4.4.

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

During this inspection, activities were observed and it was evident from the patients' engagement and participation that they were enjoying the activities.

As previously referred to in section 3.0 a number of patients and staff were consulted during the inspection process.

All comments received from patients were positive, some of which included:

"The care is very good."

"I am happy living in the home."

"No complaints, issues are dealt with."

In addition, eight questionnaires were returned by patients and all responses received indicated that they were either 'very satisfied' and/or 'satisfied' across all four domains.

Questionnaire responses were received from four relatives and two staff. All responses were positive and no additional written comments were included.

Areas for improvement

No areas for improvement were identified in this domain.

Number of requirements	0	Number of recommendations	0
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4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. However, a review of a care record for an identified patient and observations made, evidenced that a patient accommodated in the nursing unit was not appropriately placed. As previously discussed, this matter was being dealt with by management at the time of the inspection (see section 4.3). Although, a recommendation is made that prior to admission the assessment carried out should include a thorough review of information received from other care providers including family members as appropriate to ensure that any associated factors or risks are identified and inform the decision as to whether or not the placement is appropriate.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

A copy of the complaints procedure was displayed in the home. Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

A sample review of audit records evidenced that these were not completed robustly; some audit findings were contrary to the findings of the inspection. Whilst some areas for improvement had been identified through the auditing processes, there was limited evidence in the audit records reviewed that the areas for improvement had been re-audited to check compliance.

For example; there was a lack of evidence that the care planning process was accurate and reliable and that the recommendations of other health care professionals were adhered to at all times. In addition, audits that had been undertaken of patient care records were of no intrinsic value to the monitoring of the standard of care planning and care documentation.

Audits that had been completed in relation to wound care management in February 2017 were incomplete and an action plan had not been developed in regards to shortfalls identified.

A review of the monthly monitoring reports, as required under Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005, demonstrated they had not identified some of the concerns and/or issues identified at this inspection. Where shortfalls had been identified, there was no evidence that these matters had been followed up in subsequent regulation 29 monitoring reports to ensure quality improvement. A recommendation made at a previous inspection was not met and has been subsumed into a requirement made in relation to governance arrangements.

These deficits in senior management oversight had the potential to impact negatively on patients' health and welfare. These matters were discussed at the serious concerns meeting held, 20 March 2017. A requirement has been made in regards to governance arrangements.

Areas for improvement

A requirement has been made in regards to governance arrangements and a recommendation has been made in relation to information obtained as part of the pre- admission process.

Number of requirements	1	Number of recommendations	1
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5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Norma McAllister, registered manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP via web portal for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements	
<p>Requirement 1</p> <p>Ref: Regulation 12 (1) (a) (b)</p> <p>Stated: Second time</p> <p>To be completed by: 31 March 2017</p>	<p>The registered person must ensure that the treatment provided to each patient meets their individual needs and reflects current best practice. This relates specifically to the management of nutrition including weight loss, food and fluid intake and wound care.</p> <p>Ref: Section 4.2 & 4.4</p> <hr/> <p>Response by registered provider detailing the actions taken: Management of nutrition continues to be monitored weekly for residents that have weight loss. Some of these residents are on the undernutrition monitoring service which is a portal inhealthcare website which the dietician monitors each Monday following the upload of current information on the nutritional status of the residents. Other residents who are not on this system but have weight loss are also monitored and checked weekly by the Registered Manager. Monthly weights are carried out for all residents and these are monitored by the Registered Manager and any that give concern are monitored more closely. Food and fluids charts are in place for identified residents and these are being monitored. Wound care plans and charts are being audited and checked ensuring that plans are being adhered to and that the documentation reflects practice. If there are changes from the plan the reason for that change is identified and the plan changed where appropriate.</p>
<p>Requirement 2</p> <p>Ref: Regulation 13 (4)</p> <p>Stated: Second time</p> <p>To be completed by: 31 March 2017</p>	<p>The registered person must ensure that medications are administered as prescribed.</p> <p>Particular attention should focus on the prescribing and administration of nutritional supplements.</p> <p>Ref: Section 4.2 & 4.3</p> <hr/> <p>Response by registered provider detailing the actions taken: The MARS sheet and the Kardex reflect accurately the prescribing and administration of nutritional supplements. All residents that are on supplements have had charts checked and cross referenced. This includes changes that have been directed from the dietician. An example being the dietician on occasion requesting the withholding of supplements for a week for some residents.</p>
<p>Requirement 3</p> <p>Ref: Regulation 16</p> <p>Stated: Second time</p> <p>To be completed by: 31 March 2017</p>	<p>The registered persons must ensure care records are kept under review and updated in accordance with changes in the patient's condition to reflect any recommendations made and /or treatment required by the multidisciplinary team.</p> <p>Ref: Section 4.2 & 4.4</p> <hr/> <p>Response by registered provider detailing the actions taken:</p>

	<p>Records are being monitored ensuring that changes to the residents care is updated. Records of the multidisciplinary team are checked cross referencing to the care plan.</p>
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<p>Requirement 4</p> <p>Ref: Regulation 19 (1) (a), schedule 3, (3) (k)</p> <p>Stated: Second time</p> <p>To be completed by: 31 March 2017</p>	<p>The registered person must ensure contemporaneous records of all nursing care provided to the patient, are recorded accurately, to evidence actual care and treatment given, and accounts for any concerns or deficits identified.</p> <p>Particular attention should focus on the areas identified on inspection.</p> <p>Ref: Section 4.2 & 4.4</p> <p>Response by registered provider detailing the actions taken: Wound care, repositioning , fluid charts and bowel charts are being monitored as well as looking for appropriate action by the registered nurse. Should there be issues the corresponding date for the nurse on duty is identified and they are being required to account for their practice.</p>
<p>Requirement 5</p> <p>Ref: Regulation 14 (4)</p> <p>Stated: First time</p> <p>To be completed by: 5 May 2017</p>	<p>The registered person must ensure that staff are trained commensurate with their role and responsibilities in the following areas:</p> <ul style="list-style-type: none"> • medicines management including the use of PRN medication • restraint and the use of restrictive practice. <p>Monitoring systems should be in place to ensure that the training has been effective and the learning embedded into practice. Records of training should be retained for inspection.</p> <p>Ref: Section 4.3 & 4.4</p> <p>Response by registered provider detailing the actions taken: Medication training by Boots was undertaken 29th March 2017. Training for challenging behaviour and the use of restraint is scheduled for the 2.05.17</p>
<p>Requirement 6</p> <p>Ref: Regulation 13 (1) (a) (b)</p> <p>Stated: First time</p> <p>To be completed by: 31 March 2017</p>	<p>The registered person must make proper provision for the nursing and where appropriate, treatment and supervision of patients.</p> <p>This requirement is made in regards to the shortfalls identified at this inspection but not limited to.</p> <p>Ref: Section 4.2, 4.3 & 4.4</p> <p>Response by registered provider detailing the actions taken: Nutrition and weight loss are monitored weekly for the residents identified as being at risk. Wound Management is audited and is checked weekly. Repositioning charts are being monitored and checked. Regimes that have been put in place are being checked and any change to that plan is investigated and practice addressed. Safe administration of medicine is being monitored. Training organised for the 2.05.17 for challenging behaviour and restrictive practice. The resident referred to in the report was an inappropriate placement and they were relocated 10. 03.17 the day after the unannounced</p>

<p>Requirement 7</p> <p>Ref: Regulation 10 (1)</p> <p>Stated: First time</p> <p>To be completed by: 28 April 2017</p>	<p>The registered person must ensure that robust governance arrangements are in place to ensure the safe and effective delivery of care to patients. These should include; comprehensive auditing systems and monthly monitoring reports with robust action plans and evidence that actions have been followed up to ensure quality improvements.</p> <p>Ref: Section 4.2 & 4.4</p> <hr/> <p>Response by registered provider detailing the actions taken: Auditing systems and action plans are in place and areas that are identified for action are allocated to named people and are closed off in timeframes set out. Should those time frames change or are impacted by circumstances then that will be documented in review off the action plan. This then will be followed up and closed.</p>
<p>Recommendations</p>	
<p>Recommendation 1</p> <p>Ref: Standard 19.4</p> <p>Stated: Second time</p> <p>To be completed by: 28 April 2017</p>	<p>The registered manager should ensure that registered nurses are provided with training, as appropriate, on the care planning process. This should include risk assessments, assessments of needs, care planning, evaluations and record keeping.</p> <p>Ref: Section 4.2 & 4.4</p> <hr/> <p>Response by registered provider detailing the actions taken: Appropriate training has been given through supervisions to all registered nurses in Ardmhacha. Care files have been examined with the named nurse through supervision sessions and they have had the audit process of care plans explained as well as the risk assessments and assessment of needs. Ongoing monitoring and spot checking is being undertaken by the registered manager. Any shortfalls identified are being addressed. Known changes to residents condition are being looked for in the care plans by the Registered Manager.</p>
<p>Recommendation 2</p> <p>Ref: Standard 21 Criteria 6</p> <p>Stated: First time</p> <p>To be completed by: 31 March 2017</p>	<p>The registered person should ensure that risk assessments are undertaken in relation to continence management. Care plans are developed and/or reviewed in line with outcomes of such risk assessments.</p> <p>Ref: Section 4.4</p> <hr/> <p>Response by registered provider detailing the actions taken: Continence assessments are in place for the residents and the elimination care plan reflects the information identified in the continence assessment.</p>
<p>Recommendation 3</p> <p>Ref: Standard 1 Criteria 3</p> <p>Stated: First time</p> <p>To be completed by:</p>	<p>The registered person should ensure that prior to admission the assessment carried out should include a thorough review of information received from other care providers including family members as appropriate to ensure that any associated factors or risks are identified and inform the decision as to whether or not the placement is appropriate.</p> <p>Ref: Section 4.4 & 4.6</p>

31 March 2017	<p>Response by registered provider detailing the actions taken: Pre-assessments to be undertaken by the Registered Manager working in collaboration with social worker and family members. Care management reviews requested in a timely manner to address issues and consider permanency of placement. This review relates to the confirmation and agreement that the placement is appropriate.</p>
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Please ensure this document is completed in full and returned via web portal



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