Unannounced Care Inspection Report
10 April 2018

Ard Mhacha Nursing Home

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

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 74 persons.

3.0 Service details

Organisation/Registered Provider: Runwood Homes Ltd **Responsible Individual:** Mr Gavin O'Hare-Connolly	**Registered Manager:** Mrs Norma McAllister
Person in Charge at the time of inspection: Norma McAllister	**Date manager registered:** 23 October 2015
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment. PH (E) - Physical disability other than sensory impairment – over 65 years. Residential Care (RC) DE – Dementia.	**Number of registered places:** 74 comprising: 39 NH-DE 15 RC-DE

4.0 Inspection summary

An unannounced inspection took place on 10 April 2018 from 10.15 to 18.00.

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.

The term 'patients' is used to describe those living in the home which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to the arrangements for the provision of staff training and development, induction processes, and adult safeguarding. There was also evidence of good practice identified in relation to the environment, management of complaints, accident and incidents, teamwork and communication between residents, staff and other key stakeholders. Activities provided also had positive outcomes for patients.

Areas for improvement were identified in relation to the management and recording of food and fluids, pressure management and records pertaining to wound management.

Patients described living in the home in positive terms. Comments are included within the report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	2	*2

*The total number of areas for improvement under the standards includes one which has been stated for the second time.

Details of the Quality Improvement Plan (QIP) were discussed with Gavin O Hare Connolly, responsible individual and Norma McAllister, registered manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

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

4.2 Action/enforcement taken following the most recent inspection dated

The most recent inspection of the home was an unannounced finance inspection undertaken on 10 November 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the finding of this inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing
- the returned QIP from the previous care inspection
- the previous care inspection report
- pre- inspection assessment

During the inspection the inspector met with five patients individually and with others in small groups and one patient's representatives. Questionnaires were also left in the home to obtain feedback from patients and their representatives.

A poster was given to the registered manager to display in the staff area inviting them to provide feedback to RQIA via an online survey.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- duty rota for all staff from 9 to 15 April 2018
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- one staff recruitment and induction file
- staff training records
- incident and accident records
- seven patient care records
- three patient care charts including food and fluid intake charts and reposition charts
- staff supervision and appraisal planners
- a selection of governance audits
- staff meeting records
- resident/relative meeting records
- complaints record
- compliments received
- RQIA registration certificate
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated

The most recent inspection of the home was an unannounced finance inspection.
The completed QIP was returned and approved by the finance inspector. This QIP will be validated by the finance inspector at the next finance inspection.

6.2 Review of areas for improvement from the last care inspection dated 10 October 2017

<table>
<tr><th colspan="3">Areas for improvement from the last care inspection</th></tr>
<tr><th colspan="2">Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Regulation 18 (2) (c)

Stated: First time</td><td>The registered person shall plan and adhere to a programme of refurbishment to replace the bedroom and dayroom furniture.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A discussion with the registered manager and a review of the environment evidenced that this area for improvement has been addressed.</td></tr>
<tr><th colspan="2">Action required to ensure compliance with The Care Standards for Nursing Homes (2015)</th><th>Validation of compliance</th></tr>
<tr><td rowspan="2">Area for improvement 1

Ref: Standard 46 Criteria 12

Stated: First time</td><td>The registered person shall monitor standards of hand hygiene among staff and carry out regular hand hygiene audits to ensure standards are being met and maintained. Records for audits completed should be retained and available for inspection.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
Discussions held with staff, observations and a review of information evidenced that this area for improvement has been met.</td></tr>
<tr><td rowspan="2">Area for improvement 2

Ref: Standard 4

Stated: First time</td><td>The registered person shall ensure that risk assessments and care plans are reviewed following a patients discharge from hospital. A body map and an assessment of all wounds and pressure damage should be completed and any relevant documentation updated accordingly.</td><td rowspan="2">Not met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
A review of care records evidenced that this area for improvement had not been met.

Please refer to section 6.5 for further detail.</td></tr>
</table>

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

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. A review of the staffing rota for week commencing 9 April 2018 evidenced that the planned staffing levels were adhered to. The registered manager discussed the outcomes of recent recruitment and advised that in the interim, the home were block booking agency nurses to fulfil shifts. Discussions held with agency staff confirmed this information and that they were knowledgeable regarding the needs of the patients and the operational matters of the home. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Discussion with patients, representatives and staff evidenced that there were no concerns regarding staffing levels.

Staff recruitment information was available for inspection; the records for one staff member were reviewed. The record was maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced AccessNI checks were sought, received and reviewed prior to staff commencing work and records were maintained. Discussion with staff and review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. Discussion with agency staff confirmed that they had received an induction for their initial shift and a competency and capability assessment had been completed if they had the role and responsibility of being in charge of the home in the absence of the registered manager.

Discussion with the registered manager and review of records evidenced that the arrangements for monitoring the registration status of nursing and care staff was appropriately managed in accordance with Nursing and Midwifery Council (NMC) and Northern Ireland Social Care Council (NISCC).

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Arrangements were in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified.

Discussion with the registered manager and review of training records evidenced that they had a system in place to ensure staff attended mandatory training. Training is completed via e-learning and face to face training for practical components and training that is specific to the operational needs of the home. Staff who had recently been recruited confirmed that the training provided was informative and provided them with the necessary knowledge and skills for fulfil their roles. Some staff spoken with expressed an interest in receiving training in Palliative Care. This information was shared with the registered manager who agreed to make arrangements to facilitate this request. Post inspection, information had been received by RQIA to confirm that the training has been organised for 8 May 2018.

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Review of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last inspection confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms, clinical rooms and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Since the last inspection, a number of areas within the home have been re-decorated and at this inspection work was ongoing.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Within the nursing dementia unit prescribed thickening agents were observed being stored in the dining room. The potential risks associated with this practice were discussed with the deputy manager, given the category of care of patients living in this area of the home. The deputy manager addressed this matter immediately and agreed to take appropriate actions to ensure any potential risks were managed appropriately. This matter was brought to the attention of the registered manager. This matter will be monitored during subsequent care inspections to ensure that the actions taken have been maintained.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, adult safeguarding, infection prevention and control, and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of seven patient care records evidenced that a range of validated risk assessments were completed as part of the admission process. There was evidence that risk assessments informed the care planning process in most instances. Care records evidenced that appropriate referrals had been made to healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians and recommendations made had been included. There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

However the following shortfalls were identified in some of the care records reviewed.

The review of care records for one patient re-admitted to the home following hospitalisation identified that risk assessments and care plans had not been reviewed and/or updated in a timely manner. Risk assessments were not accurately and consistently completed and reviewed in accordance with changes in the patient's condition. Care plans were either not in place, or not sufficiently reviewed in response to the changing needs of patients. Discrepancies were also identified in relation to some of the information recorded. This had been stated as an area for improvement at a previous inspection; however it continued not to be met and has been stated again.

There was a lack of evidence to demonstrate that safe, effective care was being delivered consistently, in regards to the management of food and fluids and pressure management.

Food and fluid charts were inconsistently recorded with evidence of long gaps between entries and in some cases no entries were recorded. Fluid charts were not always reconciled and the information was not consistently recorded in the daily evaluation notes. A comparison of information recorded within food and fluid charts and daily progress notes for individual patients identified inconsistencies and inaccuracies. Entries in the progress notes were often vague and meaningless, for example, "eating and drinking well", with no indication if this was accurate. Registered nurses did not make any record of the action they had taken when food and /or fluid intake was inadequate. There was a lack of evidence to demonstrate that registered nurses had oversight of this aspect of care delivery. An area for improvement has been made.

A review of wound care records for an identified patient evidenced although there was evidence that the treatment had been delivered this was not consistently recorded within the patient's wound care records. For example; registered nurses on occasions had only recorded this information in the diary. This is not in keeping with best practice guidelines and an area for improvement has been made.

A review sample of repositioning charts for an identified patient evidenced that on some occasions care was not being delivered in accordance with the patients' care plan. The care plan indicated that the patient required two hourly repositioning however a review sample of records evidenced gaps of up to and including 12 hours between positional changes. This was concerning given that there was evidence that the patient had some pressure damage to their sacrum. Similarly, there was no evidence that these records were being monitored and reviewed by registered nurses and corrective actions taken. An area for improvement has been made.

Discussion with staff and a review of the duty rota evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that the shift handover provided the necessary information regarding any changes in patients' condition.

A discussion with the registered manager and a review of information confirmed that staff meetings had been held and records were maintained.

Staff 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.

A discussion with the registered manager and a review of information confirmed that staff meetings had been held and records were maintained. A review of records evidenced that patient and/or relatives meetings were held. Patients and representatives spoken with expressed their confidence in raising concerns with the home's staff /management.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to teamwork, communication between residents, staff and other key stakeholders.

Areas for improvement

Areas for improvement were identified in relation to the management and recording of food and fluids, pressure management and records pertaining to wound management.

	Regulations	Standards
Total number of areas for improvement	2	1

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs as identified within the patients' care plan. 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. Questionnaires for patients (ten) and their representatives (ten) were left with the registered manager for distribution. No responses were received.

As previously discussed, five patients were spoken with individually and others were spoken with in small groups. Comments from patients included the following:

"being looked after very well"
"the staff are good and kind".

Relatives who spoke with the inspector commented positively regarding the standard of care provided to their relative, the caring attitude of the staff and the overall management of the home.

The inspector spoke with ten staff to include; registered nurses, care and ancillary staff. A poster inviting the staff to complete an online survey was provided. At the time of writing this report no responses were received.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date will be reviewed by RQIA and shared with the registered manager for their information and action as required.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. There was evidence that suggestions for improvement had been considered and used to improve the quality of care delivered.

Observation of the lunch time experience and evening meal evidenced that this was managed appropriately. Staff were observed offering and providing assistance in a discreet and sensitive manner when necessary. The food served appeared appetising and patients appeared to be enjoying their meals.

A range of activities were available to patients in the home. Patients expressed that they enjoyed these and that it helped them spend their day. One patient spoken with showed the inspector the work that they had done in the garden and it was clear that they were proud of same.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The registration certificate was up to date and displayed appropriately. Discussion with the registered manager and review of records and observations evidenced that the home was operating within its registered categories of care.

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 review of the duty rota evidenced that the registered manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff/patients/representatives evidenced that the registered manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team.

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 review of notifications of incidents to RQIA since the last care inspection confirmed that these were managed appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in accordance with best practice guidance in relation to falls, wound management, care records, infection prevention and control, hand hygiene, environment, complaints, incidents/accidents. The results of audits had been analysed and appropriate actions taken to address any shortfalls identified and there was evidence that the necessary improvement had been embedded into practice.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Discussion with the registered manager and review of records evidenced that Regulation 29 monitoring visits were completed in accordance with the regulations. An action plan was generated to address any areas for improvement. Copies of the reports were available for patients, their representatives, staff and trust representatives.

Discussions with staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that if the action outlined in the QIP is not taken to comply with regulations and standards this may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all areas for improvement identified 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.

7.1 Areas for improvement

Areas for improvement have been identified where action is required to ensure compliance with The Nursing Home Regulations (Northern Ireland) 2005 and The Care Standards for Nursing Homes (2015).

7.2 Actions to be taken by the service

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The registered provider should confirm that these actions have been completed and return the completed QIP via Web Portal for assessment by the inspector.

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref**: Regulation12 (4) (a) **Stated:** First time **To be completed by:** Immediate from the date of inspection	The registered person shall ensure that food and fluids are provided in adequate quantities and at appropriate intervals. Records should be maintained in accordance with best practice guidelines and reviewed by registered nurses to ensure that the nutritional needs of patients are being appropriately met. Ref: 6.4
	Response by registered person detailing the actions taken: New documentation has been implemented.The Deputy Manager has undertaken supervisions with the care staff re better information being documented.Nurses are being reminded of their responsibilities for monitoring the carers records and signing them off. The records are being monitored regularly by the Deputy Manager.
Area for improvement 2 **Ref:** Regulation 13 (1) (a) **Stated:** First time **To be completed by:** Immediate form the date of inspection	The registered person shall ensure that patients are repositioned in accordance with their care plan to maintain and prevent pressure damage. Records should be maintained in accordance with best practice guidelines. Ref: 6.4
	Response by registered person detailing the actions taken: Repositioning records are being monitored and the nurses are required to ensure that these records are being completed properly. Deputy Manager is auditing and spot checking this documentation.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref:** Standard 4 **Stated:** Second time **To be completed by:** 30 June 2018	The registered person shall ensure that risk assessments and care plans are reviewed following a patients discharge from hospital. A body map and an assessment of all wounds and pressure damage should be completed and any relevant documentation updated accordingly. Ref: 6.2 & 6.4
	Response by registered person detailing the actions taken: Check list for residents returning from hospital has been implemented so that all clinical staff are clear on what needs to be in place following discharge from hospital. The nurse who was responsible for receiving the resident identified during this inspection has had supervision and has been made aware of the timely documentation that is required on residents return from hospital.

Area for improvement 2 **Ref**: Standard 4 Criteria 9 **Stated:** First time **To be completed by:** 30 June 2018	The registered person shall ensure that in accordance with NMC guidelines, contemporaneous nursing records are kept of all nursing interventions. This relates specifically to wound management. Ref: 6.4
	Response by registered person detailing the actions taken: Wound care audits are completed monthly and spot checked ensuring that they are completed correctly. Some wounds currently being managed by podiatry. Wound evaluation being documented by podiatrist. Nursing records are being checked ensuring that nursing interventions are recorded.

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

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