Unannounced Care Inspection Report
3 May 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

1.0 Summary

An unannounced inspection of Ard Mhacha House Care Centre took place on 3 May 2017 from 10.25 to 16.45.

This inspection was undertaken to determine what progress had been made in addressing the requirements and recommendations made during the previous care inspection on 9 March 2017, to re-assess the homes level of compliance with legislative requirements and the DHSSP's Minimum Standards for Nursing Homes and to determine if the home was delivery safe, effective and compassionate care and if the service was led.

A review of records, discussion with the registered manager and staff and observations of care delivery evidenced that all of the requirements and recommendations made as a result of previous inspections have been complied with. This inspection resulted in no requirements and recommendations being made.

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	0	2

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.

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 9 March 2017. Following the inspection and the lack of progress identified since the previous inspection 9 March 2017, the registered persons attended a serious concerns meeting in RQIA on 20 March 2017, to discuss the inspection findings and to provide RQIA with a detailed and comprehensive action plan which illustrated how the home would return to compliance. A request was made by RQIA that the action plan was reviewed and revised to reflect the matters discussed. RQIA were satisfied with the revised action plan.

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.

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

Specific methods used in this inspection include the following:

Prior to inspection we analysed the following records:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- the action plan submitted following the previous care inspection
- pre inspection assessment audit

During the 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 seven patients individually and the majority of others in smaller groups, six care staff, three registered nurses, two catering staff and one patient's representatives.

The following information was examined during the inspection:

- validation evidence linked to the previous QIP
- staffing arrangements in the home
- four patient care records
- accident and incident records
- audits in relation to care records
- records relating to adult safeguarding
- complaints
- staff training records
- monthly quality monitoring reports in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 9 March 2017

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be followed up during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 9 March 2017

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** Second 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.	**Met**
	Action taken as confirmed during the inspection: A review of care records identified that this requirement had been met in all areas outlined. Refer to section 4.3.2 for further detail.	
Requirement 2 **Ref:** Regulation 13 (4) **Stated:** Second time	The registered person must ensure that medications are administered as prescribed. Particular attention should focus on the prescribing and administration of nutritional supplements.	**Met**
	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 Practitioner and other health care professionals.	

Requirement 3 **Ref:** Regulation 16 **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: A review of patient care records confirmed that a range of validated risk assessments and care plans were completed as part of the admission process, reviewed and updated as required. Care plans reviewed evidenced that any recommendations made by the multidisciplinary team for example; the Dietician, Tissue Viability Nurses (TVN) were referenced in the care plan. Refer to section 4.3.2 for further detail.	
Requirement 4 **Ref:** Regulation 19 (1) (a), schedule 3, (3) (k) **Stated:** Second time	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. Particular attention should focus on the areas identified on inspection.	**Met**
	Action taken as confirmed during the inspection: A review of care records to include; food and fluid intake charts, wound care records, accidents and incident records, personal care records evidenced that this requirement was met. Refer to section 4.3.2 for further detail.	
Requirement 5 **Ref:** Regulation 14 (4) **Stated:** First time	The registered person must ensure that staff are trained commensurate with their role and responsibilities in the following areas: • medicines management including the use of PRN medication • restraint and the use of restrictive practice 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.	**Met**

	Action taken as confirmed during the inspection: A review of training records and a discussion with staff evidenced that training had been provided for staff in regards to the areas outlined above. Training in regards to medicines management had been provided by Boots on 28 March 2017 and additional dates were being organised. Training in relation to restraint and the use of restrictive practices was taking place at the time of the inspection.	
Requirement 6 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time	The registered person must make proper provision for the nursing and where appropriate, treatment and supervision of patients. This requirement is made in regards to the shortfalls identified at this inspection but not limited to.	**Met**
	Action taken as confirmed during the inspection: A review of care records pertaining to the management of food and fluids, wound care, accidents and incidents evidenced that safe effective and compassionate care was being delivered in regards to patients assessed needs and care plans in place. Refer to section 4.3.2 for further detail.	
Requirement 7 **Ref:** Regulation 10 (1) **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: Discussion with the registered manager, a review of auditing systems and processes confirmed that this requirement had been met. Refer to section 4.3.5	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 19.4 **Stated:** Second time	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.	**Met**
	Action taken as confirmed during the inspection: A discussion with the registered manager, registered nurses and a review of care records and information evidenced that this recommendation was met. One to one supervisions had been carried out with all registered nurses re; the care planning process with particular focus on the shortfalls identified at the last inspection. A review of care records evidenced that the learning had been embedded into practice.	
Recommendation 2 **Ref:** Standard 21 Criteria 6 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of three care records evidenced that risk assessments had been completed in relation to continence management. Risk assessments informed the care planning process.	
Recommendation 3 **Ref:** Standard 1 Criteria 3 **Stated:** First time	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.	**Met**
	Action taken as confirmed during the inspection: A review of a care record for a patient recently admitted to the care home evidenced that a pre-admission assessment had been completed prior to their admission to the home. The assessment included all relevant information and additional information from the referring Trust.	

4.3 Inspection findings

4.3.2 Care practices and care records

Staff interactions with patients were observed to be compassionate, caring and timely. Consultation with seven patients individually and with others in smaller groups, confirmed that patients were afforded choice, privacy, dignity and respect. 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.

A review of four patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed and updated as required. Risk assessments informed the care planning process and both were reviewed as required. Overall the standard of record keeping and documentation had improved since the last inspection. However, a recommendation has been made to ensure that care plan evaluation statements are 'meaningful.' For example; entries such as "care plan valid" was evidenced in records reviewed in the Cathedral Unit.

A review of two care records in relation to the management of wounds indicated that when a patient required wound care and or pressure care management appropriate actions were taken. These included wound assessment and care plans being updated on a regular basis. There was evidence that the care and treatment provided was reflective of that outlined in the care plan. Where applicable, specialist healthcare professionals were involved in prescribing care in relation to the management of wounds. A review of repositioning records evidenced that positional changes were carried out in accordance with the schedule in place. Pressure relieving equipment was in place and being used appropriately.

A review of information evidenced that patients' weights were being monitored and recorded accordingly. Records reviewed identified any weight loss and/or gain and subsequent actions taken. A sample review of food and fluid intake charts evidenced improvement in this area of practice. The information recorded included food and fluids offered and refused. There was evidence that food and fluids were offered at regular intervals. Supplements given were also recorded. Charts reviewed evidenced that the total 24 hour fluid intake was calculated and totalled and subsequently recorded in the patient's daily progress notes. A comparison of information recorded within food and fluid charts and the daily progress notes confirmed the accuracy of the recordings across the two records in most instances. Entries recorded accurately reflected when food and fluid intake was satisfactory and/or inadequate; there was evidence that appropriate actions had been taken when intake was poor for example; communication with the General Practitioner and Dietician.

A review of bowel management records and additional information evidenced that safe, effective care was being delivered in this area of practice. Continence risk assessments were completed and included detail in relation to both urinary and bowel management, the assessment outlined the patient's bowel pattern but did not indicate the type as per the Bristol Stool Chart. However, information recorded in bowel management monitoring records was reflective of the 'Bristol Stool Chart' and the information detailed in the care plan. A sample review of daily progress notes evidenced that patients' bowel function was recorded appropriately and there was evidence that the information was being monitored by registered nurses and management.

The review of the accident and incident reports confirmed that the falls risk assessments and care plans were consistently completed and updated when incidents occurred, care management and patients' representatives were notified appropriately.

Areas for improvement

One recommendation has been made in relation to the recording of 'meaningful statements' used for evaluating care plans.

Number of requirements	0	**Number of recommendations**	1

4.3.3 Consultation

During the inspection, we met with seven patients, six care staff, four registered nurses, two catering staff and one patient's representatives.

Staff

The majority of staff spoken with were satisfied with the care delivered and other services provided in the home. Staff spoken with commented positively regarding the management and leadership of the home. One staff member spoken with advised that there had been a lot of staff who had recently left, some of which had not been replaced and some new staff had started and that the workload was very busy due to new staff being inducted and also the high use of agency. Given that there was no impact on patient care identified during the inspection and the patients' needs were evidentially being met, these comments were relayed to the registered manager to address.

Patients

All patients spoken with during the inspection commented positively about the care they received and the management of the home.

Some comments included:
"Very happy, all staff good day and night, when I need help it is provided."
"Everything is good; I enjoyed the church service this morning."
"All good, very happy."

We also issued ten questionnaires to staff and relatives respectively; and five questionnaires were issued to patients. At the time of writing this report no questionnaires were returned within the timeframe specified.

Areas for improvement

No areas for improvement were identified during the inspection

Number of requirements	0	**Number of recommendations**	0

4.3.4 Environment

A review of the home's environment was undertaken which included a random sample of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be reasonably cleaned and tidy, well decorated and warm throughout.

A sluice room observed in the Navan unit was very untidy and an odour was evident. This was brought to the attention of the registered manager who took immediate actions. Prior to the completion of the inspection the areas was re-checked by the inspector and was observed as satisfactory.

A number of toilet seats were also observed as “broken” the registered manager advised that replacements had been ordered and would be replaced accordingly.

During the inspection, it became apparent that there was no provision for patients who “smoked”. A discussion was held with the registered manager who confirmed that there was no formal facility provided. The registered manager was advised of the importance; that appropriate arrangements are in place to facilitate this in a way which ensures the patients safety and dignity. These arrangements should adhere to the “Guidance on Service Users Smoking in Residential Care and Nursing Homes, RQIA 2013. A recommendation has been made in this regard.

Areas for improvement

A recommendation has been made in regards to the arrangements for patients who smoke.

Number of requirements	0	**Number of recommendations**	1

4.3.5 Management and governance arrangements

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. All those consulted with knew who the registered manager and other members of the senior management team were and stated that they were available at any time if the need arose. Following the last inspection, undertaken on 9 March 2017 management support had been provided. Since the last inspection there was evidence that the governance arrangements in place were more robust which resulted in positive outcomes for safe effective care and the operational management of the home. For example; quality monitoring systems were sufficiently robust to identify shortfalls and effective measure had been taken to drive improvements. These included nut not limited to; care plan audits; home manager audits; wound care practice audits; and weight monitoring audits.

Discussion with the registered manager and review of records evidenced that quality monitoring visits were completed in accordance with Regulation 29 of the Nursing Homes Regulations (Northern Ireland) 2005. A review of the report completed for March 2017, evidenced that the shortfalls identified at the last inspection had been reviewed and followed up appropriately.

Observations of patients evidenced that the home was operating within its registered categories of care.

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 inspection confirmed that these were managed appropriately, in keeping with Regulation 30 of the Nursing Homes Regulations (Northern Ireland) 2005.

Areas for improvement

No areas for improvement were identified during the inspection

Number of requirements	0	Number of recommendations	0

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 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 to 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

Recommendations	
Recommendation 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 3 August 2017	The registered person should ensure that all entries in care records are meaningful and evaluate the effectiveness of the care plan in place. **Ref: Section 4.3.4**
	Response by registered provider detailing the actions taken: Home Manager continues to audit care files ensuring that the care plan is meaningful and that the evaluations are reflective of the ongoing needs.
Recommendation 2 **Ref:** Standard 44 Criteria 14 **Stated:** First time **To be completed by:** 3 August 2017	The registered persons should ensure that provision is made, in accordance with legislation and guidance for patients who smoke. **Ref: Section 4.3.5**
	Response by registered provider detailing the actions taken: Smoking Shelter quotes have been obtained and are ready to be forwarded to Runwood. This will give an outdoor shelter for the residents that smoke.

Please ensure this document is completed in full and returned via web portal

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