Unannounced Care Inspection Report
10 October 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 & Michael Lavelle

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: Mrs Norma Mc Allister	**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 October 2017 from 09.30 to 18.00 hours.

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 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 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.

There were examples of good practice found in relation to staff recruitment and development; risk management and the cleanliness of the home's environment. Risk assessments and care plans were in the majority well maintained, and there was evidence of good communication between residents, staff and other key stakeholders. There were good governance systems, management and leadership in the home.

Areas for improvement under the standards were identified in relation to hand hygiene practice among staff and re-assessment of patients' needs following discharge from hospital with particular focus on skin integrity and wounds.

Patients said they were happy with the care provided and enjoyed living in the home. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

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	*1	2

The total number of areas for improvement above includes one regulation which was not reviewed at this inspection and has been carried forward for review at the next care inspection.

Details of the Quality Improvement Plan (QIP) were discussed with Norma Mc Allister, 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 19 August 2017

The most recent inspection of the home was an unannounced care inspection undertaken on 19 August 2017. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings 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
- 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 six patients individually, nine staff, and one patient's representative. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

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

The following records were examined during the inspection:

- staffing arrangements in the home
- two staff personnel files to review recruitment and selection
- staff induction, supervision and appraisal records
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- three patient care records
- two patient care charts including food and fluid intake charts and repositioning charts
- a selection of governance audits
- complaints record & compliments received
- RQIA registration certificate
- certificate of public liability
- 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 19 August 2017

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

This QIP was not validated fully at this inspection due to the compliance dates identified for some areas of improvement and a number of items have been carried forward for validation at the next care inspection.

6.2 Review of areas for improvement from the last care inspection dated 19 August 2017

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref:** Regulation 27 (2) (d) **Stated:** First time	The registered person shall replace the carpets in the reception area and in the identified bedrooms.	**Met**
	Action taken as confirmed during the inspection: A discussion with the registered manager confirmed that carpets had been replaced in the three identified bedrooms. The carpet in the reception area has not been replaced and observations made at this inspection found the carpet cleaned and in good condition.	
Area for improvement 2 **Ref:** Regulation 32 **Stated:** First time	The registered person shall ensure that the identified bathrooms are not maintained as stores. The bathrooms should be returned to their original use and if required storage is needed then a variation application should be made to RQIA to approve the change of usage.	**Met**
	Action taken as confirmed during the inspection: Observations of these bathrooms evidenced that this area for improvement had been met.	
Area for improvement 3 **Ref:** Regulation 18 (2) (c) **Stated:** First time	The registered person shall plan and adhere to a programme of refurbishment to replace the bedroom and dayroom furniture.	**Carried forward to the next care inspection**
	Action taken as confirmed during the inspection: Due to the date of compliance this area for improvement was not reviewed during this inspection.	

Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		Validation of compliance
Area for improvement 1 **Ref:** Standard 12 **Stated:** First time	The registered person shall provide a choice of dessert on the daily menu.	**Met**
	Action taken as confirmed during the inspection: An observation of the serving of the lunchtime meal evidenced that this area for improvement was met.	
Area for improvement 2 **Ref:** Standard 25 **Stated:** First time	The registered person shall review the dining experience in the dementia units from a dementia perspective, in order to enhance choice and independence.	**Met**
	Action taken as confirmed during the inspection: An observation of the serving of the lunchtime meal evidenced that the areas for improvement identified had been met.	
Area for improvement 3 **Ref:** Standard 48 **Stated:** First time	The registered person shall confirm to RQIA that the identified magnetic self-closure has been repaired.	**Met**
	Action taken as confirmed during the inspection: A discussion with the registered manager and observations made at this inspection evidenced that this area for improvement had been met.	

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 October 2017 evidenced that the planned staffing arrangements were generally adhered to. The registered manager advised that the home had recently recruited a number of care staff and registered nurses and final recruitment checks were in progress. In the interim, the home were continuing to use agency staff to fulfil shifts, these staff were being 'blocked booked' to ensure continuity of care.

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 and staff evidenced that there were no concerns regarding staffing levels. A questionnaire returned by a relative included a written comment stating that, "The home could do more with more staff as they have a lot to do with all the patients and they don't get enough time with individuals. The staff are always busy." This information was shared with the registered manager for consideration and actions as deemed appropriate. No other concerns were raised.

A review of two staff personnel files evidenced that staff recruitment information was available for inspection and records were maintained in accordance with Regulation 21, Schedule 2 of the Nursing Homes Regulations (Northern Ireland) 2005. Records evidenced that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work and records were maintained. For agency staff, their profile was maintained accordingly.

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. The induction programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme, the employee and the inductor sign the record to confirm completion and to declare understanding and competence.

A discussion with the registered manager and staff and review of information evidenced that systems were in place to monitor staff performance and ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, undertook competency and capability assessments and completed annual appraisals.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and records were kept up to date. Training was completed via e-learning (electronic learning) and face to face training for practical components. Training for Fire Safety, Moving and Handling and First Aid was scheduled and a list of staff that was required to attend was displayed. It was noted that the home had achieved 100% compliance for training in Dementia Care, this is commended. Discussion with the registered manager and review of training records evidenced that they had a robust system in place to ensure staff attended mandatory training.

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. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedure into practice. A safeguarding champion had been identified. An information folder was available in each unit for staff to access.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

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 care 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 and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. As previously discussed a number of home improvements have been made since the last inspection and the registered manager discussed further plans for redecoration and refurbishment of some areas within the home. These included but not limited to; the dining rooms; bedrooms and lounge areas.

Fire exits and corridors were observed to be clear of clutter and obstruction. Infection prevention and control measures were adhered to in the majority and equipment was appropriately stored. Some observations made identified that staff were not always adhering to best practice in hand hygiene. These observations were discussed with the registered manager who advised that hand hygiene audits were completed. Information was displayed on infection prevention and control and resources were available to assure compliance. Whilst this information was acknowledged an area for improvement under the standards has been made to drive the necessary improvement.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, risk management and the home's environment.

Areas for improvement

An area for improvement under the standards was identified in regards to best practice in hand hygiene among patients and staff.

	Regulations	Standards
Total number of areas for improvement	0	1

6.5 Is care effective?

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

Review of three 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.

Care records accurately reflected the assessed needs of patients, were kept under review and where appropriate, adhered to recommendations prescribed by other healthcare professionals such as tissue viability nurse specialist (TVN), speech and language therapist (SALT) or dieticians.

A sampling of food and fluid intake charts confirmed that patients' fluid intakes were monitored. The information recorded included food and fluids offered and refused. Supplements given were also recorded. Charts reviewed evidenced that the total 24 hour fluid intake was calculated and subsequently recorded in the patient's daily progress notes. 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. Patients who had been identified as being at risk of losing weight had their weight regularly monitored. Audits in relation to weights and nutritional management were undertaken by the registered manager on a monthly basis and action plans were devised accordingly. A discrepancy which was identified in regards to one care record reviewed at the time of the inspection was rectified by information submitted to RQIA post inspection.

A review of two care records in relation to the management of wounds and/or pressure damage evidenced that in the majority this area of care was managed appropriately. Care plans in place specified the prescribed treatment as per the advice provided by the Tissue Viability Nurse. Wound care documentation was maintained in accordance with best practice guidelines. The care and treatment provided was reflective of that outlined in the care plan with the exception of a shortfall identified in one of the care records reviewed. A review of information identified that a body map had not been completed on their return to the home following discharge from hospital and no assessment of the wound had been undertaken for the three days after their return to the home. Although a review of information evidenced that there was no deterioration in the wound the importance of this review was discussed with the registered manager and this has been identified as an area for improvement under the standards.

A review sample of repositioning records evidenced that these were maintained in accordance with best practice guidance, care standards and legislation. Reviews of repositioning records for one patient evidenced that on some occasions there were periods of up to and including four hours were staff had not repositioned them. The care plan identified that the patient required 'two hourly' repositioning. Staff advised that the patient had the ability to reposition themselves independently and were observed doing so at the time of the inspection. The appropriateness of this intervention was discussed with both the registered manager and registered nurses who agreed to update the care plan.

A number of patients had pressure relieving mattresses on their beds, to prevent skin breakdown. A system was in place to check that the mattresses were set correctly for the weight of the patient however; some mattresses checked at the time of the inspection were not accurate. A discussion with staff indicated that the settings may have been altered by patients who wandered about the unit. The registered manager agreed to review the current system to assure that the equipment in place was effective for use. Post inspection, the registered manager has confirmed by an email correspondence that appropriate actions have been taken to address same.

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.

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. Nursing and senior care staff attended daily flash meetings at 11:00am Staff shared any concerns they had about their patients and discussed their progress. Staff felt this was beneficial as they were able to receive advice from more experienced colleagues. The registered manager advised that the 11:00am meeting assisted her knowledge of issues in the home. This is good practice.

Discussion with the registered manager confirmed that staff meetings were held on a regular basis 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.

All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

Discussion with the registered manager and review of records evidenced that patient and/or relatives meetings were held on a regular basis. Minutes were available. Copies of the most recent inspection reports were available at the main reception for staff, patients and their representatives to access.

Areas of good practice

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

Areas for improvement

An area for improvement was identified in regards to the re-assessment of wounds following discharge from hospital.

	Regulations	Standards
Total number of areas for improvement	0	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. Consultation with patients confirmed that they 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. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent.

We observed the serving of the lunch time meal in the Cathedral Unit. The tables were set attractively, with a range of condiments. The menu was displayed in the dining room in various formats to aid patients understanding, these included a pictorial version. The lunch appeared appetising and choices were available for both the main course and dessert. Patients spoken with acknowledged that the food was tasty. The atmosphere was quiet and patients were encouraged to eat their meals. Staff were observed assisting patients as deemed appropriate.

Patients consulted with also confirmed that they were able to maintain contact with their families and friends. There was evidence of a variety of activities in the home and discussion and observations made at the time of inspection evidenced that patients appeared to enjoy same and were observed participating at various levels. Discussion with patients and staff evidenced that arrangements were in place to meet patients' religious and spiritual needs within the home.

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.

Patients and their representatives confirmed that when they raised a concern or query, they were taken seriously and their concern was addressed appropriately.

From discussion with the registered manager, staff and a review of the compliments received in letters and thank you cards, there was evidence that the staff cared for the patients and their relatives in a kind manner.

During the inspection, we met with nine patients individually and the majority of others in small groups. As previously reported staff from different teams and one patient's relative were also consulted. Some comments received are detailed below:

Staff

"Very happy no concerns good teamwork."
"My induction was very good and informative."
"Everything is going well."
"The home has improved in the last year the patients seem to be happier."

Patients

"Staff are great, always checking on you."
"Excellent care, they do a very, very good job."
"More singing and yarns would be good."
"First class staff and the food is very good."

Patients' representatives

"Very pleased care is good and we are kept well informed a relatives meeting held in July was very informative."

We also issued ten questionnaires to staff and relatives respectively and eight questionnaires to patients. Five questionnaires were returned by relatives. Responses received from relatives indicated that they were either very satisfied or satisfied that the care delivered was safe, effective and compassionate and that the service was well led. No questionnaires were returned by patients and staff, within the timeframe for inclusion in this report.

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

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 in this domain 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 and public liability certificate was displayed appropriately. Discussion with the registered manager and review of records/observation 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 some 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 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.

There were systems 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, 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. These included drug and equipment alerts and alerts regarding staff that had sanctions imposed on their employment by professional bodies.

Discussion with the registered manager and review of records evidenced that Regulation 29 monthly monitoring quality 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 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 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:** Regulation 18 (2) (c) **Stated:** First time	The registered person shall plan and adhere to a programme of refurbishment to replace the bedroom and dayroom furniture. Ref: Section 6.1 & 6.2
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this will be carried forward to the next care inspection.
Action required to ensure compliance with The Care Standards for Nursing Homes (2015).	
Area for improvement 1 **Ref:** Standard 46 Criteria 12 **Stated:** First time **To be completed by:** 30 November 2017	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. Ref: Section 6.4
	Response by registered person detailing the actions taken: Hand hygiene observational audit tool implemented to observe and document standards of hand hygiene. Hand hygiene is also part of the monthly infection control audit.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** 30 November 2017	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: Section 6.5
	Response by registered person detailing the actions taken: Risk assessments and careplans to be monitored following patients discharge from hospital. Residents in hospital are identified on the board in Managers office and follow up check will be undertaken ensuring that all relevant documentation is in place.Body map and assessment of all wounds and pressure damage should be completed and relevant documentation updated. Making agencies aware of their responsibility as nurses that they are expected to manage this documentation too when a residents comes back into the home.

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

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews