Ard Mhacha House Care Centre
RQIA ID: 1869
Desart Lane South
Armagh
BT61 8AR

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Unannounced Care Inspection
of
Ard Mhacha House Care Centre

29 February 2016

The Regulation and Quality Improvement Authority
Hilltop, Tyrone & Fermanagh Hospital, Omagh, BT79 0NS
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1. Summary of Inspection

An unannounced care inspection took place on 29 February 2016 from 10.00 to 17.00. RQIA were assisted by a lay assessor who met with patients and /or patient's representatives / relatives to obtain their views on the quality of care provided within the home.

This inspection was underpinned by **Standard 19 - Communicating Effectively; Standard 20 – Death and Dying and Standard 32 - Palliative and End of Life Care.**

On the day of the inspection, the care in the home was found to be safe, effective and compassionate. The inspection outcomes found no significant areas of concern; however, some areas for improvement were identified and are set out in the Quality Improvement Plan (QIP) within this report.

Recommendations made as a result of this inspection relate to the DHSSPS Care Standards for Nursing Homes, April 2015.

For the purposes of this report, the term 'patients' will be used to described those living in Ard Mhacha House Care Centre which provides both nursing and residential care.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 03 November 2015.

1.2 Actions/Enforcement Resulting from this Inspection

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

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	1

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

2. Service Details

Registered Organisation/Registered Person: Countrywide Care Homes Limited/Mrs Victoria Craddock	Registered Manager: Mrs Norma McAllister
Person in Charge of the Home at the Time of Inspection: Mrs Norma Mc Allister	**Date Manager Registered:** 23 October 2015
Categories of Care: NH-I, NH-PH(E), NH-PH, NH-DE, RC-DE	**Number of Registered Places:** 74
Number of Patients Accommodated on Day of Inspection: 70	**Weekly Tariff at Time of Inspection:** £470.00 - £593.00

3. Inspection Focus

The inspection sought to assess progress with the issues raised during and since the previous inspection and to determine if the following standards and theme have been met:

Standard 19: **Communicating Effectively**
Theme: **The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)**

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- discussion with the registered manager
- discussion with a selection of staff on duty
- consultation with patients and/or representatives
- observation of care delivery
- observation of patient and staff interactions
- tour of the home and a review of a random selection of patient bedrooms, bathrooms and communal areas; and
- evaluation and feedback.

Prior to inspection the following records were analysed:

- notifiable events since November 2015
- the registration status of the home
- written and verbal communication received by RQIA since the previous care inspection
- the returned quality improvement plan (QIP) from the last care inspection and the previous care inspection report.

The following records were examined during the inspection:

- policies and procedures pertaining to the inspection themes
- a sample of training records
- compliment records
- complaint records; and
- five patient care records.

5. The Inspection

5.1 Review of Requirements and Recommendations from the Previous Inspection

The previous inspection of the home was an unannounced pharmacy inspection dated 09 February 2016. The completed QIP was returned and approved by the pharmacy inspector.

5.2 Review of Requirements and Recommendations from the Last Care Inspection 03 November 2015

Last Care Inspection Statutory Requirements		Validation of Compliance
Requirement 1 **Ref:** Regulation 13 (1)(a)(b) **Stated:** First time	The registered person must ensure that the identified patient's needs are assessed and that a treatment plan is developed and implemented accordingly and recorded to evidence all care provided, with particular reference to wound and/or pressure care management. An urgent actions record was issued.	**Met**
	Action taken as confirmed during the inspection: Review of the identified patient's record evidenced that all aspects of this requirement had been actioned appropriately.	

Requirement 2 **Ref:** Regulation 12 (1)(a)(b) **Stated:** First time	The registered person must ensure that the treatment and any other services provided to each patient, meets their identified assessed needs and reflects current best practice in relation to pressure care. Care records should be reflective of assessment outcomes and care interventions required to meet assessed needs and the care delivered.	**Met**
	Action taken as confirmed during the inspection: A review of two patient's care records pertaining to pressure care management evidenced that these were reflective of care outcomes and the care interventions were appropriate to meet the assessed needs. Records evidenced that treatment had been delivered in accordance with the plan of care, reviewed and updated accordingly. This requirement has been met.	
Last Care Inspection Recommendations		**Validation of Compliance**
Recommendation 1 **Ref**: Standard 5 **Stated:** Third and final time	The registered person shall review the identified care practices to ensure health and welfare of patients.	**Met**
	Action taken as confirmed during the inspection: At this inspection all patients appeared well presented and comfortable in their surroundings. A review of daily personal care records for patients evidenced the care delivered and /or not delivered. Supervisions in regards to personal care delivery have been completed since the last care inspection. A discussion with the registered nurse advised that these records are monitored on a daily basis by senior care staff and registered nurses and followed up accordingly. This requirement has been met.	

Recommendation 2 **Ref**: Standard 16 **Stated:** First time	It is recommended that records of all complaints include all communications with complainants; the result of any investigations; the action taken; whether or not the complainant was satisfied with the outcome; and how this level of satisfaction was determined. A recommendation has been made.	**Met**
	Action taken as confirmed during the inspection: A review of the complaints record evidenced that complaints had been appropriately managed and recorded in accordance with the recommendation made.	

5.3 Standard 19 - Communicating Effectively

Is Care Safe? (Quality of Life)

A policy and procedure was available on communicating effectively which reflected current best practice, including regional guidelines on Breaking Bad News, reviewed September 2015.

Regional guidelines on Breaking Bad News were available and staff spoken with was aware of the policies, procedures and guidelines and knew where to access them.

Discussion with the registered manager and staff advised that this area of practice was included as part of the induction process and that informal training had been completed. The registered manager advised that they were in the process of co-ordinating training and this was included. Post inspection, an email correspondence was received by RQIA confirming that training had been organised for 15 March & 5 April 2016.

Discussion with staff confirmed that they were knowledgeable of how to communicate effectively with patients, relatives, other healthcare professionals and each other. Staff were also aware of the importance of effective communication in ensuring continuity and quality of care.

Is Care Effective? (Quality of Management)

Care records reviewed, included reference to the patient’s communication needs and actions required to manage barriers such as, language, cognitive ability, or sensory impairment.

Care records reviewed evidenced that patients and/or their representatives were involved in the assessment, planning and evaluation of care to meet their assessed needs.

Staff consulted clearly demonstrated their ability to communicate sensitively with patients and their families. It was evident that staff were aware of the individual needs and wishes of their patients.

Is Care Compassionate? (Quality of Care)

Observation of the delivery of care and interactions between patients and staff clearly evidenced that communication was compassionate and considerate of the patient's needs. Patients were treated with dignity and respect.

Patients who could verbalise their feelings on life in Ard Mhacha House Care Centre commented positively in relation to the care they were receiving from staff and the attitude of staff. Patients who could not verbalise their feelings were observed to be relaxed and comfortable in their surroundings and with staff interactions.

Positive comments were also recorded by relatives in letters and cards received by the home.

Areas for Improvement

There were no areas for improvement identified in relation to communicating effectively.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.4 Theme: The Palliative and End of Life Care Needs of Patients are Met and Handled with Care and Sensitivity (Standard 20 and Standard 32)

Is Care Safe? (Quality of Life)

Policies and procedures on the management of palliative and end of life care and death and dying were available in the home, reviewed October 2015. These documents reflected best practice guidance such as the Gain Palliative Care Guidelines, November 2013, and included guidance on the management of the deceased person's belongings and personal effects.

Discussion with the registered manager advised that training dates were currently being organised and post inspection an email correspondence confirmed that training had been booked for 15 March & 5 April 2016. The registered manager advised that the palliative care link nurse had provided some informal training in relation to the core aspects of care in this area of practice. Discussion with staff indicated that they were knowledgeable in this regard.

A copy of the GAIN Palliative Care Guidelines, November 2013, was available in the home. Staff spoken with were aware of the guidance and knew where to access them for reference.

Discussion with staff and a review of care records confirmed that there were arrangements in place for staff to make referrals to specialist palliative care services.

Discussion with the registered manager, nursing staff and a review of care records evidenced that staff were proactive in identifying when a patient's condition was deteriorating or nearing end of life and that appropriate actions had been taken.

A palliative care link nurse has been identified for the home and there was evidence available that they had attended the Trust link meetings. A discussion with the link nurse advised their role, function and responsibilities in relation to same and how this could further enhance the care and knowledge in this area of practice.

Is Care Effective? (Quality of Management)

A review of care records and discussion with staff evidenced that patients' needs for palliative and end of life care were assessed and reviewed on an ongoing basis. This included the management of hydration and nutrition, pain management and symptom management. There was evidence that the patient's wishes and their social, cultural and religious preferences were also considered.

Care records evidenced discussion between the patient, their representatives and staff in respect of death and dying arrangements were deemed appropriate.

There was evidence that referrals had been made to the specialist palliative care team and where instructions had been provided, these were evidently adhered to.

Management had made reasonable arrangements for relatives/representatives to be with patients who had been ill or dying. Staff were able to describe clearly how the families would be supported during this time and enabled to stay overnight in the home when their loved ones were dying.

A review of notifications of death to RQIA since the 1 January 2015 confirmed that any death occurring in the home was notified appropriately.

Is Care Compassionate? (Quality of Care)

Discussion with staff and a review of care records evidenced that patients and/or their representatives had been consulted in respect of their cultural and spiritual preferences regarding end of life care. Staff demonstrated an awareness of patient's expressed wishes and needs as identified in their care plan.

Staff consulted demonstrated clearly their compassion for the patients, their relatives and friends. Observations of staff interactions with patients demonstrated that they had a detailed knowledge of the patient's individual and personalised needs. Staff ensured that the patients were afforded privacy, dignity and respect at all times.

Discussion with the registered manager, staff and a review of the compliments record, evidenced that arrangements in the home supported relatives when their loved one was dying. There was evidenced within the compliments/records that relatives had commended the management and staff for their efforts towards the family and patient.

Some examples of comments made by relatives included:

"we greatly appreciated your love & concern for … during all her years – it was evident how much you cared for her – above the call of duty & in the end days you kept her comfortable, dignified and pain free"

"thank you for everything you did for … over the years. Very much appreciated"

"thank you all for the care and dignity shown to …"

Discussion with the registered manager and a review of the complaints records evidenced that no concerns were raised in relation to the arrangements regarding the end of life care of patients in the home.

Areas for Improvement

There were no areas for improvement identified in relation to palliative and end of life care.

Number of Requirements:	**0**	**Number of Recommendations:**	**0**

5.5 Additional Areas Examined

5.5.1. Consultation with Patients, Staff and Patient Representatives/ Relatives

Patients and Patient Representatives/Relatives

A lay assessor met with nine patients individually in order to obtain patients' views on the quality of care provided within the home. All patients indicated that they were generally happy with their life in the home, their relationship with staff and the provision of care.

Some comments included:

- "staff are very welcoming – it's a safe place to be".
- "very happy and content and I can't speak highly enough of the staff looking after me".
- "can't think of anything that could be improved, am very content".
- "very happy in this home I like looking from my room window into the garden- it reminds me of my own garden at home, the staff are always very helpful".
- "the staff are all very attentive and helpful – enjoy the activities that are offered".
- "the activities don't always interest me and sometimes the days are long".

The lay assessor visited all four units during the inspection and observed various activities and staff interactions. The feedback provided by the lay assessor at the end of the inspection was positive describing the home as "calm and ordered with a very pleasant and fun aura". Patients were observed as well dressed and comfortable in their surroundings and staff were pleasant and enthusiastic in their interactions with the patients.

The provision of activities was discussed during feedback in relation to the comment received. The registered manager advised that the home had recently recruited a second activity staff member and that there were plans in place to review the provision of activities which would include discussions with patients in relation to their personal preferences and areas of interest. The registered manager advised that the appointment of the additional staff member would increase the provision for individual activities as well as group ones.

The inspector met with the majority of patients during the course of the inspection. Comments from patients were very positive about all aspects of care and services they received. No concerns were brought to the attention of the inspector by any of the patients consulted.

The lay assessor also met with five relatives visiting at time of the inspection. Overall, comments were positive about the care being delivered and that if they had any queries they would speak with the nurse or registered manager which was dealt with in a professional manner. Relatives spoken with expressed their satisfaction with the standard of care and felt that their relatives were well cared for with compassion and skill. Some comments included:

"I commend the staff in how they handle patients and relatives".
"staff are really good to the residents and family. Very friendly to all".
"I am very happy with the care given to my father".

One relative spoken with stated that generally they were happy with the care but commented that sometimes there was a lack of the "personal touch" and that staff changes at times led to a lack of continuity of care. These comments were discussed at feedback and the registered manager provided an assurance that these comments would be addressed appropriately.

The inspector met with two relatives and comments received were positive regarding the standard of care, the home environment and the level of communication maintained in regards to the well-being of their loved ones. No concerns were raised.

Staff

In addition to speaking with seven staff on duty, ten questionnaires were provided for staff not on duty at time of the inspection. The registered manager agreed to forward these to the staff selected. At the time of writing this report four had been returned.

Three of the four returned questionnaires indicated that staff had received training in relation to safeguarding, reporting poor practice/whistleblowing and patient consent. Staff identified the need for further training in relation to palliative and end of life care which has been organised and has been previously referred to in section 5.4. In addition, staff indicated that they were satisfied or most satisfied that patients were treated with dignity and respect and that the patients' needs and wishes were respected and met. Staff confirmed that the care was safe, effective and compassionate. No concerns were raised.

Additional comments included:

"I feel the home has come a long way this last year. Staff feel happier and everyone tries to work as a team".

"I think Ard Mhacha is a very well looked after nursing home. The staff are fantastic at working together. Patients are well presented in all units and well cared for".

5.5.2. Environment

A review of the home's environment was undertaken which included observation of a random sample of bedrooms, bathrooms, lounges and dining rooms in each unit.

The home was found to be warm, well decorated, fresh smelling and clean throughout. Housekeeping staff were spoken with at the inspection and commended for their efforts.

Patients were observed relaxing in their bedroom or in one of the lounge areas available. During the inspection, the delivery of activities were observed and evidenced that the patients were actively participating and engaging with the staff delivering the activities. Patients were complimentary in respect of the home's environment.

5.5.3. Care records

A review of care records evidenced that in some instances care staff were recording entries in relation to care delivered for example in relation to personal care. This area of practice was discussed with a sample of care staff and their responses indicated that they would benefit from additional training to enhance their knowledge of record keeping and to ensure that all written entries are in line with policy, best practice standards and legislative requirements. A recommendation has been made.

5.5.4. Management arrangements

The registered manager has been in post since October 2015. Discussion with staff and patients confirmed that they felt the 'new manager' to be a positive influence on the day to day operation of the home. Discussion with staff evidenced that they were aware of their role, function and responsibilities. Staff spoken with advised that the training and guidance provided to them had enhanced their knowledge, understanding and the rationale for carrying out care practices. Management are commended for their efforts.

5.5.5. Regulation 29 Reports

A review of a sample of regulation 29 reports evidenced that these were completed in a very detailed and comprehensive manner. However, it was evident that some actions were being carried forward for lengthy periods from the initial time scale identified. These findings were discussed with senior management post inspection who agreed to review and take the necessary actions.

Areas for Improvement

A recommendation has been made that additional training is provided for staff in accordance with their roles and responsibilities in relation to record keeping.

Number of Requirements:	0	Number of Recommendations:	1

6. Quality Improvement Plan

The issue(s) identified during this inspection are detailed in the QIP. Details of this QIP were discussed as part of the inspection process. The timescales commence from the date of inspection.

The registered person/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 person/manager 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 your premises. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises the RQIA would apply standards current at the time of that application.

6.1 Statutory Requirements

This section outlines the actions which must be taken so that the registered person/s meets legislative requirements based on The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Nursing Homes Regulations (Northern Ireland) 2005.

6.2 Recommendations

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

6.3 Actions Taken by the Registered Manager/Registered Person

The QIP must be completed by the registered person/registered manager to detail the actions taken to meet the legislative requirements stated. The registered person will review and approve the QIP to confirm that these actions have been completed. Once fully completed, the QIP will be returned to nursing.team@rqia.org.uk and assessed by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the home. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained in this report do not absolve the registered provider/manager from their responsibility for maintaining compliance with minimum standards and regulations. It is expected that the requirements and recommendations set out in this report will provide the registered provider/manager with the necessary information to assist them in fulfilling their responsibilities and enhance practice within the home.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref**: Standard 39 **Stated:** First time **To be Completed by:** 31 May 2016	It is recommended that training in relation to record keeping is provided for care staff and others in line with their individual roles and responsibilities to ensure that their knowledge, skills and competence are up to date for safe effective practice. A record of training should be retained.
	Response by Registered Person(s) Detailing the Actions Taken: Record keeping training is scheduled for the 19th April for Care staff. The training is being delivered by Health Matters and a record of training will be retained in the training file which is located in the managers office. The records will also be recorded on e-learning as a practical course. This will be for each person who has particapated. Further training will be booked ensuring that all have an opportunity to attend documentation training.

Registered Manager Completing QIP	Norma McAllister	**Date Completed**	18.04.16
Registered Person Approving QIP	V.Craddock	**Date Approved**	18/04/16
RQIA Inspector Assessing Response	Sharon Loane	**Date Approved**	26.04.16

Please ensure this document is completed in full and returned to Nursing.Team@rqia.org.uk from the authorised email address