The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: **Strangford Court**

Provider: **Ann's Care Homes Ltd**

Date of Inspection: **7 January 2025**

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider:	Ann's Care Homes
Responsible Individual:	Mrs Charmaine Hamilton
Registered Manager:	Ms Claire Quail

Service Profile –
This home is a registered nursing home which provides nursing care for up to 38 patients. The home is divided into two units; The Oakland Suite provides care to people who have a learning disability and The Millar Suite provides care to people who have a dementia. There are communal dining and lounge areas within both units.

2.0 Inspection summary

An unannounced inspection took place on 7 January 2025 from 9.40am to 4.20pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to assess progress with the areas for improvement identified, by RQIA, during the last care inspection on 15 January 2024; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection established that safe, effective and compassionate care was delivered to patients and that the home was well led. As a result of this inspection the previous area for improvement was assessed as having been addressed by the provider and no new areas for improvement were identified. Details can be found in the main body of this report.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

3.0 The inspection

3.1 How we Inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the provider to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning Trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "Staff are good," and, "I like it here".

Patients told us that staff offered choices to patients throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options and where and how they wished to spend their time.

Relatives consulted during the inspection were complimentary in regards to the care their loved one was receiving. One told us,"Staff go above and beyond. The care is A1. No concerns at all".

We received five questionnaire responses from patients' visitors/relatives. All responses were positive and complimented the manager and the staff on the care that they provided. One commented, "We have peace mind that he is well cared for". We didn't receive any responses from the staff online survey.

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing. A relative commented, "It is vitally important for me to know that my mother is safe and they (the staff) do that and with bells on; couldn't do any more".

Patients said that there was enough staff on duty to help them. Staff said there was good teamwork and that they felt well supported in their role and that they were satisfied with the staffing levels. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

3.3.2 Quality of Life and Care Delivery

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patient's needs, their daily routine, wishes and preferences.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs. A relative commented, "I am extremely happy with the care Claire and her team provide".

Staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner and by offering personal care to patients discreetly. Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

All nursing and care staff received a handover at the commencement of their shift. Staff confirmed that the handover was detailed and included the important information about their patients, especially changes to care, that they needed to assist them in their caring roles. Handover sheets were shared with staff containing the pertinent patient details.

Patients may require special attention to their skin care. For example, some patients may need assistance to change their position in bed or get pressure relief when sitting for long periods of time. These patients were assisted by staff to change their position regularly and records maintained. Staff were aware of the actions to take if a patient's skin was starting to show signs of pressure damage.

Where a patient was at risk of falling, measures to reduce this risk were put in place. In addition, falls were reviewed monthly for patterns and trends to identify if any further falls could be prevented. A review of accident records evidenced that the correct actions had been taken following a fall in the home and the correct persons notified.

A new catering manager had been recruited since the last inspection. The catering arrangements between Strangford Court and the neighbouring Lecale Lodge Nursing Home continued to operate well with no concerns noted.

Patients had good access to food and fluids throughout the day and night. Nutritional risk assessments were completed monthly to monitor for weight loss or weight gain. Nutritional care plans were in line with the recommendations of the speech and language therapists and/or the dieticians. Patients were safely positioned for their meals and the mealtimes were well supervised. Food served appeared appetising and nutritious. Staff communicated well to ensure that every patient received their meals in accordance with the patients' needs.

Pateints were encouraged with fluid intake throughout the day. Staff were aware of the actions to take should a patient become dehydrated.

An activities planner was available for review. Two staff were employed to oversee the activitiy provision in the home. Staff confirmed that the planner was not always adhered too depending on the patients' preferences for the day. Activities were conducted in groups and/or on a one to one basis depending on patients' preferences. One to one activities included walks, nail care, hairdressing, massage or chats.

A patient/relative survey had been completed during 2024 to ascertain their perceptions of the service provision in the home. The results of the survey had been collated and included within the home's Annual Quality Report (AQR). The AQR included planned improvements the home's management team wished to make as a result of the whole survey findings.

Relatives told us that staff always kept them up to date with their loved one's care. One told us, "I sleep better knowing they are in good hands and in a good community". Another commented, "The care is very good and the staff are very caring".

Patients spoken with told us they enjoyed living in the home and that staff were friendly.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Patients care records were held confidentially.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs.

Nursing staff recorded regular evaluations about the delivery of care. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

3.3.4 Quality and Management of Patients' Environment

The home was clean and tidy and patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, warm and comfortable.

Fire safety measures were in place to protect patients, visitors and staff in the home. Actions required from the most recent fire risk assessment had been completed in a timely manner.

There was evidence that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Ms Claire Quail has been the Registered Manager in this home since 10 March 2011. Staff commented positively about the manager and described them as supportive, approachable and always available to provide guidance.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place.

There was a system in place to manage any complaints received. A compliments log was maintained and any compliments received were shared with staff.

Staff told us that they would have no issue in raising any concerns regarding patients' safety, care practices or the environment. Staff were aware of the departmental authorities that they could contact should they need to escalate further. Patients and their relatives spoken with said that if they had any concerns, they knew who to report them to and said they were confident that the manager or person in charge would address their concerns.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Ms Claire Quail as part of the inspection process and can be found in the main body of the report.

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