The Regulation and Quality Improvement Authority

Inspection Report

25 October 2021

Strathearn Court

Type of service: Nursing Home
Address: 229 Belmont Road, Belfast, BT4 2AH
Telephone number: 028 9065 6665

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: Four Seasons Health Care **Responsible Individual:** Mrs Natasha Southall	**Registered Manager:** Mr John Cherian **Date registered:** 16 October 2020
Person in charge at the time of inspection: Marites Astorga – Deputy Manager	**Number of registered places:** 55
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. PH(E) - Physical disability other than sensory impairment – over 65 years. TI – Terminally ill.	**Number of patients accommodated in the nursing home on the day of this inspection:** 46
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 55 patients. Patients' bedrooms are located over two floors. Patients have access to communal lounges, dining rooms and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 25 October 2021 from 9.25 am to 5.45 pm. The inspection was carried out by a care inspector.

The inspection sought to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Patients spoke positively about living in the home and said they felt well looked after by the staff. Patients less able to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

Staff were seen to treat the patients with respect and compassion.

Areas requiring improvement identified are discussed in the main body of the report.

RQIA were assured that the delivery of care and service provided in Strathearn Court was safe, effective and compassionate and that the home was well led. Addressing the areas for improvement will further enhance the quality of care and services in the home.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

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

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection RQIA will seek to speak with patients, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The daily life within the home and how staff went about their work was observed.

A range of documents were examined to determine that effective systems were in place to manage the home.

The findings of the inspection were discussed with Marites Astorga, Deputy Manager, at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we spoke to 15 patients, both individually and in small groups, 10 staff and two relatives.

Patients said that staff were helpful and friendly and the food was good. They commented that "staff couldn't do enough for you day or night" and "staff are very good to me". Patients said that they would like more planned activities to be available within the home.

Staff said that they felt well supported but that communication could be improved on occasions.

Relatives said that communication was good and that they had no concerns about the care provided.

A record of compliments received about the home was kept and shared with the staff team, this is good practice.

No completed questionnaires were returned within the indicated timeframe and no staff responded via the on-line survey.

Comments made by patients, staff and relatives were brought to the attention of the manager for information and action as required.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

No areas for improvement were identified as a result of the last inspection carried out on 4 March 2021.

5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to protect patients. There was a system in place to monitor the registration status of nurses with the Nursing and Midwifery Council (NMC) and care staff with the Northern Ireland Social Care Council (NISCC). Staff confirmed they were provided with an induction programme on commencement of their employment. A new staff member said that they felt very well supported during their induction.

There were systems in place to ensure staff were trained and supported to do their job. Staff said that they were provided with a range of mandatory training to enable them to carry out their roles effectively and that they were satisfied their training needs were met. Review of training records evidenced that mandatory training was provided in an online format but also face to face when required, for example, in practical moving and handling training. A training matrix and record of staffs' compliance was maintained and staff were reminded when training was due.

The manager said that the number of staff on duty was reviewed on at least a monthly basis to ensure that the needs of the patients were met. Bank or agency staff were used to cover shifts if required and recruitment was ongoing.

The staff duty rota accurately reflected the staff working in the home on a daily basis. The duty rota identified the person in charge when the manager was not on duty. An on-call weekend rota was available for staffs' information.

Staff said teamwork was good and that they felt well supported in their role. Staff also said that work was "tough at times" but staffing levels had improved and they confirmed that efforts were made to cover shifts, for example, when there was short notice sick leave.

It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way.

Staff said that they felt communication varied regarding, for example, new admissions, and also expressed a concern that they might miss new information if they had been off for a few days. This was discussed with the manager who said that occasionally an admission would have to be arranged with relatively short notice but efforts were made to ensure staff were kept up to date as far as possible. Additionally, flash meetings were convened when required, handovers were provided at the start of each shift and there was a communication diary on both floors in order to help keep staff informed and updated.

The manager confirmed that all nurses who took charge in the home in the absence of the manager had completed the relevant competency assessments. Review of records confirmed there was a supervision and annual appraisal schedule in place.

Patients said there were enough staff to help them. Two patients said they had a bit of wait for help occasionally but they knew staff were busy and would get back to them as soon as possible.

Staff said that they enjoyed working in the home and liked to see their patients looking well cared for.

Relatives said that they consistently saw the same staff in the home which they felt was great for the patients.

5.2.2 Care Delivery and Record Keeping

Staff confirmed that they received a handover at the start of each shift to keep them updated about any changes in the needs of the patients. Patients' needs were assessed at the time of 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.

Review of patients' records and discussion with staff confirmed that the correct procedures were followed if restrictive practices and equipment, for example, alarm mats or crash mats, were required. It was established that safe systems were in place to manage this aspect of care.

Where a patient was at risk of falling, measures to reduce this risk were put in place, for example, aids such as alarm mats, bed rails and crash mats were in use if required. Examination of records and discussion with staff confirmed that in the event of a fall the home's post fall protocol was implemented and the relevant care records were evaluated and updated.

Staff were observed to be very prompt in assisting a patient who wasn't feeling well. They dealt with the situation appropriately, treated the patient with compassion and made sure that their dignity and privacy was maintained.

Staff displayed their knowledge of individual patients' needs and preferences. Staff were understanding and sensitive to patients' needs. It was observed that staff respected patients' privacy; they knocked on bedroom and bathroom doors before entering and discreetly offered patients assistance with their personal care needs.

Review of wound care plans evidenced that there had been consultation with the Tissue Viability Nurse (TVN) and that their recommendations were recorded. However, the wound care records reviewed did not clearly demonstrate that the wounds were being redressed as recommended. This was brought to the attention of staff. It was established that the wounds had been redressed as recommended but that the wound care records needed to be reviewed to ensure that they were contemporaneously recorded. An area for improvement was identified.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The dining experience was seen to be an opportunity for patients to socialise in the dining room if they wished or to eat in their own room or the lounge if that was their preference. During lunch it was observed that patients were provided with the range of support they required from simple encouragement through to full assistance.

The food was attractively presented and smelled appetising. Staff offered patients a choice of drinks during the meal. Staff told us how they were made aware of patients' nutritional needs to ensure that patients received the right consistency of diet. Food and fluid intake records reviewed were up to date. There was no menu on display but it was established that there was a choice of meals on offer. The lack of menu on display was discussed with the manager and the chef who explained that, following consultation with patients, they were in the process of updating the menu and had ordered new printed versions which had not yet arrived. It was agreed that a written menu will be displayed for patients until the new printed versions are available.

All the patients, with the exception of one, said that they enjoyed the food. The patient who didn't enjoy the food said that they weren't fussed on some of the meals but were always able to get an alternative that was more to their taste and that they had been able to talk to the chef about this.

Patients' weights were checked at least monthly to monitor weight loss or gain. Care records contained recommendations from the Dietician and the Speech and Language Therapist (SALT).

Review of supplemental record booklets showed that repositioning records were up to date and reflective of recommendations in care plans, however, in some booklets it was noted that not all the required details, such as mattress type and setting were recorded. There were also gaps noted in the recording of mouth care. Supplemental records should be completed in full and contemporaneously. An area for improvement was identified.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was observed to be clean, tidy, warm and fresh smelling throughout. Since the last inspection the home's reception area had been attractively redecorated and updated and the ground floor dining room floor had been replaced. Patients' bedrooms were well decorated and personalised with items that were important to them such as family photographs, pictures and ornaments. Communal lounges and dining rooms were clean, tidy and welcoming spaces for patients to spend time in.

The manager confirmed that the home had a maintenance person who undertook routine maintenance work and carried out regular maintenance checks of the environment.

Fire exits and corridors were free from any obstructions. An up to date fire risk assessment was available for review and a record of fire drills was maintained.

It was observed that several door frames throughout the home required repair and/or repainting. Additionally, several radiator covers were in need of repainting or replacement. This was discussed with the manager who confirmed that there was no current improvement plan in place regarding door frames and radiator covers. This was identified as an area for improvement.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases, for example, the home participated in the regional testing arrangements for patients and staff.

Staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. It was confirmed that staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept. Review of records confirmed that training on infection prevention and control (IPC) measures and the use of PPE had been provided.

Patients and relatives said that the home was kept clean and tidy.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day, for example, they said that staff made sure they got to the dining room for meals if that was their preference and respected their wishes if they wanted to stay in their own room. Patients said that staff took time to chat to them, listened to them if they had a concern and made efforts to ensure any issues were quickly sorted out.

The manager said that relatives' meetings have not been undertaken lately due to the continued need for social distancing. Patients' views had been sought through a dining survey and this had resulted in menus being reviewed as discussed in section 5.2.2.

The activity coordinator post was vacant. Staff said that when possible they would make an effort to provide activities, such as, playing cards and games with patients, taking time just to chat or giving manicures and hand massages. Staff said they enjoyed doing this but that if they were very busy time was limited and these activities were therefore not always offered consistently.

Some patients did say that they would like to see more activities being available in the home; one patient said they had really enjoyed armchair exercises and hoped these would be available again. Other patients said that they were content in their own rooms and were happy to spend time writing, watching TV, reading or knitting.

Comments made by patients and staff regarding activities were brought to the attention of the manager who confirmed that recruitment was underway for an activity coordinator and that a new 'Magic Moments' activity programme will be developed once a suitable person is in post. The manager will inform RQIA once recruitment has been successful and progress with activity provision will be reviewed at the next inspection. Following the inspection the manager confirmed that, until a suitable person is recruited for the activity post, existing staff will be

providing an activity programme three days per week and accompanying patients on shopping trips out of the home

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff said they assist patients to make telephone or video calls to their families and facilitate booked visits within the patients' bedrooms. Visiting arrangements were in place and managed according to the current Department of Health (DoH) guidance. The manager said the home currently had no Care Partners but information had been provided regarding this and they would be happy to facilitate the role as requested.

The manager said that patients were really enjoying visits from their families and outings for coffee or lunch again, the positive benefits of these activities were readily apparent and they were keen to encourage these arrangements within the scope of current guidelines.

Patients also said they were enjoying visits from their families once again; they spoke positively about staff and said they felt well looked after.

It was observed that staff treated the patients with respect and kindness and were responsive to requests for assistance.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection; Mr John Cherian has been the Registered Manager in this home since 16 October 2020. Staff were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to patients. There was evidence of auditing across various aspects of care and services provided by the home.

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home's safeguarding policy. The manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

Patients and their relatives said that they knew who to speak to if they had any concerns and that they were confident these would be sorted out. Relatives said that communication was good.

Review of the home's record of complaints confirmed that these were well managed. The manager said that the outcome of complaints is used as a learning opportunity to improve practices and/or the quality of services provided by the home; this is good practice.

A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly and reported appropriately.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail. Where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These reports are available for review by patients, their representatives, the Trust and RQIA.

Staff said that they found the work to be rewarding and that the manager was generally approachable although sometimes seemed very busy in which case they would be happy to take a query or concern to another senior member of staff.

6.0 Conclusion

Patients looked well cared for and were seen to be content and settled in their surroundings. It was positive to note that the manager put a plan in place to ensure an activity schedule will be provided while recruitment continues for a suitable activity coordinator.

Staff were helpful and friendly; it was clear that they knew the patients well and they were seen to be responsive to patients' needs.

The home was found to be clean, tidy, warm and fresh smelling throughout.

As a result of this inspection three areas for improvement were identified regarding wound care records, supplemental records and environmental issues. Details can be found in the Quality Improvement Plan.

Based on the inspection findings and discussions held we are satisfied that this service is providing safe, effective and compassionate care and that the service is well led by the manager. Addressing the areas for improvement will further enhance the quality of care and services in the home.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with the Care Standards for Nursing Homes (April 2015).

	Regulations	Standards
Total number of Areas for Improvement	0	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Marites Astorga, Deputy Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Ongoing from the date of the inspection.	The registered person shall ensure that wound care records clearly demonstrate the wound care being provided, are contemporaneously recorded and regularly reviewed. Ref: 5.2.2
	Response by registered person detailing the actions taken: Wound records have been checked in line with the area for improvement required following the inspection. Nursing staff have been given supervisions to ensure all care records are reviewed regularly during each dressing change. Wound and care records were reviewed by FSHC clinical auditor following the verbal feedback on the day of inspection to ensure requirements and standards are met. Registered Manager will continue to review on onging basis.
Area for improvement 2 **Ref:** Standard 4 **Stated:** First time **To be completed by:** Ongoing from the date of the inspection.	The registered person shall ensure that supplemental record books are completed in full and that a contemporaneous record of all supplemental care provision is maintained. Ref: 5.2.2
	Response by registered person detailing the actions taken: Supplemental record charts have been reviewed and staff have been given one to one supervisions to evidence accurate and contemporaneous record keeping. Spot checks have been initiated and will be ongoing to ensure accuracy and compliance.
Area for improvement 3 **Ref:** Standard 44 **Stated:** First time **To be completed by:** Ongoing from the date of the inspection.	The registered person shall ensure that an improvement plan is developed regarding door frames and radiator covers. Required actions should be undertaken taken to ensure that door frames and radiator covers are kept in a good state of repair and repainted or replaced as necessary. Ref: 5.2.3
	Response by registered person detailing the actions taken: Work has commenced to repair chipped door frames with hard plastic corners and radiator covers that require repaired/ repainted or replaced. The requirements are being followed up by the property manager.

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

The Regulation and Quality Improvement Authority

7th Floor, Victoria House
15-27 Gloucester Street
Belfast
BT1 4LS

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

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