Unannounced Care Inspection Report
13 February 2020

Sandringham

Type of Service: Nursing Home
Address: 24 Sandringham Court, Gilford Road, Portadown BT63 5BW
Tel no: 02838394194
Inspector: Joanne Faulkner

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.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes. 2015.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which provides care for up to 63 patients. The home is divided into two units; one of the units provides care to persons with dementia.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Maureen Claire Royston	**Registered Manager and date registered:** Tracey Palmer 16 August 2019
Person in charge at the time of inspection: Tracey Palmer	**Number of registered places:** 63 comprising 32-NH-DE 31-NI-I and PH
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. DE – Dementia. PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 56

4.0 Inspection summary

An unannounced inspection took place on 13 February 2020 from 09.55 hours to 15.20 hours.

This inspection was undertaken by the care inspector.

The term ‘patient’ is used to describe those living in Sandringham which provides nursing care.

The following areas were examined during the inspection:

- staffing arrangements
- environment
- care records
- adult safeguarding
- complaints
- accident/incidents
- governance arrangements

The inspection assessed progress with all areas for improvement identified in the home since the last care inspection and determined if the home was delivering safe, effective and compassionate care and if the service was well led.

Evidence of good practice was found in relation to staff attentiveness to patients and the delivery of care which took into account personal choice for patients. Staff had a good understanding of the individual needs of the patients and worked well as a team to deliver the care patients' required. The delivery of care took into account the needs, personal choice and independence of the individual patients.

No areas requiring improvement were identified.

Patients described living in the home as being a good experience/in positive terms. Patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others/with staff.

Comments received from patients, people who visit them and staff during the inspection, are included in the main body of this report.

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	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Tracey Palmer, registered manager, as part of the inspection process and can be found in the main body of the report.

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

4.2 Action/enforcement taken following the most recent inspection dated 9 September 2019

The most recent inspection of the home was an unannounced care inspection. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspection findings including registration information, and any other written or verbal information received.

During our inspection we:

- where possible, speak with patients, people who visit them about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. No questionnaires were returned to RQIA prior to the issuing of this report. A poster was provided for staff detailing how they could complete an electronic questionnaire; no responses were received within the relevant timescales.

The following records were reviewed during the inspection:

- duty rota information for all staff from 3 to 16 February 2020
- incident and accident records
- two patient care records
- a sample of governance audits/records
- complaints records
- adult safeguarding records
- the monthly monitoring reports for November and December 2019
- RQIA registration certificate

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

We would like to thank the patients, relatives and staff for their support and cooperation throughout the inspection.

6.0 The inspection

6.1 Review of areas for improvement from previous inspections

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 14.13 **Stated:** Second time	The registered person shall ensure that where any service is facilitated within the home (such as, but not limited to, hairdressing, chiropody or visiting retailers) the person providing the service and the patient or a member of staff of the home signs the treatment record or receipt to verify the treatment or goods provided and the associated cost to each patient. Ref: 6.6	**Met**
	Action taken as confirmed during the inspection: Records viewed indicated that the person providing a service to a patient and a staff member had signed the invoice to verify that the treatment had been provided. The record included details of any charges to the patients for services received.	
Area for improvement 2 **Ref**: Standard 2.8 **Stated:** Second time	The registered person shall ensure that any changes to the individual agreement are agreed in writing by the patient or their representative. The individual agreement is updated to reflect any increases in charges payable. Where the patient or their representative is unable to or chooses not to sign the revised agreement, this is recorded. Ref: 6.6	**Met**
	Action taken as confirmed during the inspection: The home provides a written agreement to all patients detailing any charges. The manager stated that patients and/or their representative will be informed of any changes.	

6.2 Inspection findings

6.2.1 Staffing

We reviewed staffing arrangements within the home. Discussions with the manager indicated that they were knowledgeable in relation to their responsibilities with regard to the regulations. Discussions with the manager and staff evidenced that there was a clear organisational structure within the home. The manager is supported by a deputy manager and a nursing sister who coordinate a team of registered nurses and healthcare assistants. In addition, there is a team of support staff which includes administrative, housekeeping, laundry, maintenance and kitchen staff and two activities coordinators.

On the date of inspection the certificate of registration was on display and reflective of the service provided. No concerns regarding the management of the home were raised during the inspection.

Discussions with the manager, staff, relatives and patients, and rota information viewed provided assurances that the home endeavours to ensure that there is at all times the appropriate number of experienced persons available to meet the assessed needs of the patients. Discussions with a number of patients and relatives during the inspection identified that they had no concerns with regards receiving the appropriate care and support.

The manager stated that staffing levels were subject to regular review to ensure the assessed needs of the patients were appropriately met. The duty rota information viewed, reflected the staffing levels discussed with the manager. Observation of the delivery of care provided evidence that patients' needs were met by the levels and skill mix of staff on duty. Staff consulted confirmed that they were satisfied the staffing levels and skill mix were sufficient to meet patients' needs.

Staff rota information viewed indicated that the care is provided by a core staff team which included agency staff when required; it was felt that this supports the home in ensuring continuity of care to patients. Staff stated that they felt that continuity of staff can have a positive impact on the patients' experience in relation to their human rights such as privacy, dignity and respect.

Staff demonstrated that they had a clear understanding of their roles and responsibilities. Discussions with patients and relatives provided assurances that they were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

Staff demonstrated that they had a good understanding of the individual assessed needs of patients and could describe the importance of respecting patients' personal preferences and choices. Throughout the inspection patients' needs and requests for assistance were observed to have been met in a timely, respectful and caring manner. Interactions between staff and patients were observed to be compassionate and appropriate. Observations of patient and staff interactions evidenced that patients were offered choice; staff provided care in a manner that promoted privacy, dignity and respect.

Patients and relatives consulted with spoke positively in relation to the care provided. Patients who could not verbalise their feelings in respect of their care they received were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. During the inspection call bells were noted to be answered promptly.

6.2.2 Environment

We reviewed the home's environment undertaking observations of a sample of bedrooms, bathrooms, lounges, dining room and storage areas within each of the two units within the home. Fire exits and corridors were observed to be clear of clutter and obstruction. Fire doors were alarmed as appropriate.

The entrance areas and a number of shared areas were noted to be well decorated, clean and uncluttered. Patients' bedrooms were clean, warm and welcoming and had been personalised to the individual interests, preferences and wishes of patients. There were no malodours detected in the home.

The lounge areas were clean, warm and welcoming; drinks were available for patients. There is an information board in the main area of the home providing information relating to fire safety, choking risk, modified diets and the role of RQIA.

Compliance with best practice on infection prevention and control (IPC) had been well adhered to. A supply of gloves and aprons were readily available to staff in both of the units and noted to be used appropriately while they were attending to patients' needs. The provision and use of handwashing facilities throughout the home was observed to be consistently utilised. Information leaflets with regard to IPC issues such as hand hygiene were available for patients and their visitors. The sluice rooms and cleaning stores were locked and cleaning chemicals were appropriately stored.

Bathrooms were clean, fresh and uncluttered; it was noted that two pull cords were not appropriately covered in keeping with best practice with regards to infection prevention and control (IPC). This was actioned immediately following the inspection.

We identified a falls mat and a mattress on a shower trolley that were damaged and needed replaced; the manager provided evidence that replacements had been ordered.

6.2.3 Care records

Care records viewed during the inspection were noted to be retained in a well organised manner. The review of care records for two patients identified that they were comprehensive and individualised; they included details of patient's likes and preferences. Records viewed included referral information received from a range of HSCT representatives and in addition included risk assessments and care plans.

Care plans viewed were noted to provide details of the specific care required by individual patients; they included details of any practice deemed to be restrictive. Staff record daily the care provided to patients. Staff stated that they aim is to support patients to be as independent as possible and to provide the care in a person centred manner.

There was evidence that registered nurses assessed, planned, evaluated and reviewed care in accordance with NMC guidelines. There was evidence that the care planning process included input from patients and/or their representatives, as appropriate. Discussions with staff and patients, and observations made provided assurances that care is provided in an individualised manner.

Records viewed indicated that there was regular communication with relevant representatives. A review of the care provided is facilitated at least annually in conjunction with relevant representatives. Staff described the benefits of regular reviews for ensuring that the needs of patients were being appropriately met and that risks are identified. Care plans and risk assessments are reviewed monthly.

There is a process for monitoring patients with significant weight loss or those patients identified to be at risk of malnutrition. Patients had been weighed monthly and a nutritional screening tool known as Malnutrition Universal Screening Tool (MUST) was utilised to determine the risk of weight loss or weight gain. Staff stated that patients had 24 hour access to food and fluids.

6.2.4 Dining experience

We observed the serving of the midday meal; the atmosphere in the dining rooms was calm and relaxed. The dining rooms were observed to be clean and uncluttered and table settings were noted to be well presented with appropriate table coverings, napkins, cutlery and condiments.

Food served was well presented and appropriate portion sizes were provided; discussion with a number of patients evidenced that they enjoyed a pleasurable dining experience. Staff were observed offering and providing assistance in a discreet and sensitive manner when necessary. Staff who were supporting patients to eat their meal were sitting close to the patients and chatting to them as they provided assistance. Food was covered when being transferred from the dining room to patients who were eating in the bedrooms or lounge areas.

A number of patients spoken with stated that the food was good and confirmed that they had a choice of menu. Comments include: “Nice.”; “We get more than enough; food is very good.”; “I like it but you won’t please everyone.”

6.2.5 Activities

There are two activity coordinators in the home, they described the need to provide a range of activities to meet the individual preferences of the patients; it was noted they support patients in an individual basis and as a group.

There was evidence that a varied programme of activities is available to patients in the home. Activities, such as art, music and crafts were part of the weekly programme. We observed a number of patients being supported to participate in a radio broadcast which is facilitated twice weekly. The patients participating in the activity were observed to be relaxed and interacting with the activity coordinator.

6.2.6 Complaints

A review of complaints received since the previous inspection, evidenced that they had been managed appropriately. From records viewed it was noted that the home retains a comprehensive record of the investigation, actions taken and outcomes of any complaint received. Complaints are audited monthly as part of the quality monitoring audit. A copy of the complaints procedure was available in the home. Patients and relatives could describe the process for raising concerns.

We reviewed a range of compliments received by the home, they included:

- "Wish to convey my sincere thanks for the care and support to ***** (patient)."
- "Thanks you all so much from the bottom of my heart for looking after mum."
- "The care dad received was second to none."

6.2.7 Adult safeguarding

A review of adult safeguarding information and discussions with the manager provided evidence that referrals made since the last inspection had been managed appropriately and in accordance with the home's policy and procedure. Adult safeguarding matters are reviewed as part of the monthly quality monitoring process.

A detailed record is retained of referrals made in relation to adult safeguarding. A safeguarding log is retained; we discussed with the manager the benefits of recording the outcome on monthly log record.

Discussions with the manager and staff demonstrated that they were knowledgeable in matters relating to adult safeguarding and the process for reporting adult safeguarding concerns. Patients and relatives knew how to raise a concern and stated that the manager and staff were approachable.

Staff could clearly describe their responsibility in relation to reporting poor practice and had awareness of the home's policy and procedure with regard to whistleblowing.

6.2.8 Incidents

A review of a sample of the accidents and incidents which had occurred within the home identified that they had been managed appropriately. There are systems in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. It was noted that details of incidents are audited monthly as part of the quality monitoring process; this assists in highlighting trends and risks, and identifying areas for improvement.

6.2.9 Consultation

During the inspection we spoke to six patients, small groups of patients in the dining room or lounge areas, three relatives and eight staff. Patients who could verbalise their views provided positive feedback in relation to the care provided by staff. As previously stated, patients unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with others.

Patient's comments

- "Not too bad; food not bad."
- "Great place; I am happy here."
- "Staff are lovely to you."
- "I have no problems."
- "Staff are good."

Staff comments

- "This is a great place, I love it. I have no concerns."
- "We are very happy."
- "The sister is great; this is a great place."
- "Patients are safe and have choice."
- "Patients are well looked after."
- "Can speak to the manager."
- "If any problems can speak to the sister; she is really lovely."
- "We have enough staff; can be a bit short staffed if staff sickness."
- "Lovely place."
- "Very happy, well supported."
- "Try to get activities that the patients are interested in."

Relatives' comments

- "This place is very well run, the staff are brilliant."
- "Nothing is a bother. My uncle is very ill; staff look after him but me too. Staff bring me tea and food."
- "I have no complaints the manager is great."
- "Manager and staff very caring, attentive and approachable."
- "Lovely place, very calm place."
- "Excellent place; my mum is here nine years."
- "The staff are like family."
- "Mummy is well cared for."
- "No complaints; the care is top notch."
- "I speak to the manager if not happy."

A matter raised by a relative relating to the consistency of food provided, was discussed with the manager. The manager provided assurances that this would be followed up with the relative and discussed with staff.

A number of the relatives who spoke to us indicated that they had no concerns in relation to the care provided to their relative. They stated that staff were approachable and felt that care provided was of a high standard. They stated that they felt their relative was well cared for and that staff are attentive in making sure their needs are met.

Patients stated that staff were friendly and approachable; they stated that they had no concerns in relation to the care provided to them.

We observed a number of staff supporting patients in the dining room and lounge areas. Staff indicated that they were respectful of the patients by asking them their choices in relation to a range of matters such as food and participation in activities. There was a relaxed, welcoming atmosphere in all the units within the home.

During the inspection the activity coordinators were encouraging and supporting patients to be involved in a radio broadcast in the home. Observations made indicated that a number of patients participate in and enjoyed this activity.

Discussion with patients, relatives, the manager and staff provided evidence that there were systems in place to obtain the views of patients and their representatives on the day to day running of the home. There was evidence that suggestions for improvement had been considered and used to improve the quality of care delivered.

Ten questionnaires were provided for distribution to the patients and/or their representatives; no responses were received prior to the issuing of this report.

At the request of the inspector, the manager was asked to display a poster within the home. The poster invited staff to provide feedback to RQIA via an electronic means regarding the quality of service provision; no responses were received prior to the issuing of this report.

6.2.10 Governance arrangements

The manager provided evidence that robust and effective systems were in place to monitor and report on the quality of care provided. Audits are completed monthly in accordance with best practice guidance in relation to infection prevention and control, falls, dependency levels, wound management, nutrition, medication, complaints, incidents/accidents and adult safeguarding.

The home has implemented a system for completing quality monitoring audits on a monthly basis and for developing a report in accordance with Regulation 29. We reviewed records that evidenced Regulation 29 monitoring visits were completed in accordance with the regulations and/or care standards. The records indicated engagement with patients, and where appropriate their representatives. The reports viewed were noted to include details of the review of the previous action plan, review of care records, staffing arrangements including staff training and registration with the relevant regulatory body. In addition a range of matters are reviewed they include, accidents/incidents, adult safeguarding referrals, nutrition/ weight loss, restrictive practice, environmental matters, wound management and complaints. An action plan is generated to address any areas for improvement identified during the visit.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints, safeguarding referrals and incidents. There was evidence of care being provided in a caring and individualised manner, and engagement with patients, relatives and other relevant stakeholders.

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

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

The Regulation and Quality Improvement Authority

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