Unannounced Care Inspection Report
29 July 2020

Sandringham

Type of Service: Nursing Home
Address: 24 Sandringham Court, Gilford Road, Portadown BT63 5BW
Tel no: 028 3839 4194
Inspectors: Jane Laird

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.

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 areas as detailed in section 3.0 of this report.

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager and date registered:** Tracey Palmer 16 August 2019
Person in charge at the time of inspection: Tracey Palmer - manager	**Number of registered places:** 63 comprising: 32 – NH – DE (East Wing) 31 – NH - I and PH (West Wing)
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:** East Wing- 27 West Wing - 28

4.0 Inspection summary

An unannounced inspection took place on 29 July 2020 from 10.30 to 18.45 hours.

Due to the coronavirus (COVID-19) pandemic the Department of Health (DoH) directed RQIA to continue to respond to ongoing areas of risk identified in homes. In response to this, RQIA decided to undertake an inspection to this home.

The following areas were examined during the inspection:

- staffing
- care delivery
- communication
- care records
- infection prevention and control (IPC) measures
- environment
- leadership and management arrangements

Details of the inspection findings and areas for improvement are discussed within section 6.2 and the Quality Improvement Plan (QIP) within this report.

Comments received from patients 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.

4.0 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	4	6

Details of the Quality Improvement Plan (QIP) were discussed with Tracey Palmer, 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.

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, registration information, and any other written or verbal information received.

This included the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned QIP from the previous care inspection
- the previous care inspection report.

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

The following records were examined during the inspection:

- staff duty rota for weeks commencing 20 July 2020 and the 27 July 2020
- four patients' daily reports and care records
- two patients' care charts including food and fluid intake charts and repositioning charts
- complaints ledger
- training records for all grades of staff
- adult safeguarding folder
- incident and accident records
- a sample of governance audits
- a sample of monthly monitoring reports from June 2020.

There were no areas for improvement from the previous care inspection.

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 previous inspection(s)

The most recent inspection of the home was an unannounced care inspection undertaken on 13 February 2020. There were no areas for improvement identified and no further actions were required to be taken following this inspection.

6.2 Inspection findings

6.2.1 Staffing

On arrival to the home at 10.30 hours we were greeted by the manager and staff who were helpful and attentive. There was a pleasant atmosphere in the home throughout the inspection and staff were observed to have friendly interactions with patients.

The manager advised us of the daily staffing levels within the home and how these levels were reviewed regularly to ensure the assessed needs of the patients were met. Review of the staff duty rotas evidenced that the planned staffing levels had been adhered to. However, on observation of the care delivery within the West Wing we had concerns regarding the staffing levels as discussed in section 6.2.2 below. The manager advised us that patient occupancy levels were due to increase on the day following the inspection and provided evidence of additional staffing levels on the duty rota.

Staff spoken with confirmed what the manager had discussed with us and that they had some concerns about the review of staffing taking into consideration patients assessed needs and dependency levels within the West Wing. While we were satisfied that staffing arrangements were kept under review; an area for improvement was made to ensure that patients' dependency levels are considered as part of any staffing review. Comments from staff included:

- "Lots of training."
- "Great induction."
- "Very supported by management."
- "It's very busy. We need more staff."
- "Great teamwork."
- "I love working here."

We also sought staff opinion on staffing via the online survey. There was no response in the time frame allocated.

6.2.2 Care delivery

Patients were mostly in their bedrooms due to the COVID-19 social isolation guidance. Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Sandringham. However, one patient expressed their dissatisfaction with the care delivery and agreed that this information could be shared with the manager. Details of the patient's dissatisfaction were discussed with the manager for action as required.

Comments from patients included:

- "Staff are wonderful."
- "Staff are looking after me well."
- "I'm happy here."
- "Staff don't answer my questions."
- "Great place. Settled the moment I arrived."

Staff were knowledgeable about the patient's needs and how to access relevant services such as dietician, general practitioner (GP), speech and language therapist (SALT) and tissue viability nurse (TVN), to ensure the assessed needs of the patient are met. We observed the delivery of care within the East Wing; patients were well presented and appeared comfortable in their surroundings.

Observation of the delivery of care within the West Wing evidenced that patients' needs were not always met by the levels and skill mix of staff on duty as discussed above in section 6.2.1. Identified patients presentation was below an acceptable standard and relevant staff were requested to attend to the patients' needs promptly by the inspector during the inspection. We identified patient's finger nails that were not being maintained, staining to a patient's feet, facial stubble on identified patients, and footwear unclean. On review of several personal care records we identified that staff had documented that they had attended to patient's hygiene needs and nail care. The manager agreed to monitor this aspect of patient care during a daily walk around the home and to address any deficits with staff accordingly. This was identified as an area for improvement.

Observation of three patient's pressure relieving mattresses confirmed that two mattresses were not set according to the correct weight of the patient. On review of patients care records the direction within the care plan was that the mattress setting must be set according to the patient's weight. This was discussed with the manager who acknowledged the importance of ensuring that the mattress is set at the correct weight of the patient to prevent skin pressure damage unless otherwise advised and agreed to review all relevant care plans. This was identified as an area for improvement.

We observed the serving of lunch. Lunch commenced at 12.30 hours and trays were delivered to patients bedrooms. Staff were observed assisting patients with their meal as necessary, however, the meals were not covered on delivery and trays were observed in a number of patients bedrooms beside and/or over the wash hand basin. This was discussed with the manager who agreed to monitor this going forward and address with relevant staff when required. This was identified as an area for improvement.

6.2.3 Communication

We confirmed through discussion with patients and staff that systems were in place to ensure good communications between the home, patient and their relatives. Some examples of the efforts made included**:** video calls, telephone calls and visits to the home under COVID-19 visiting guidance.

On the day of the inspection, the personal activity leader (PAL) discussed the current arrangements within the home to facilitate patient involvement in accordance with social distancing restrictions. The patients appeared to enjoy the interaction between the staff and each other.

6.2.4 Care records

Review of four patient care records evidenced that there were a number of deficits within care plans to direct the care required as follows:

- identified care plans did not reflect the recommended frequency of repositioning
- the type of hoist and sling was not recorded in identified care plans
- information regarding patients' recommended daily fluid intake was not included in identified care plans
- the level of assistance required with personal care was either conflicting or absent within identified care plans
- care plans for identified patient's did not accurately reflect the level of assistance with mobility and equipment required
- care plans did not accurately reflect the patients' medical history
- one identified patient's care plan with a history of weight loss did not accurately state the frequency of monitoring the patient's weight.

Specific examples were discussed in detail with the manager who acknowledged the shortfalls in the documentation and agreed to communicate with relevant staff the importance of accurately recording such information within patients' care records. In order to drive improvements, this was identified as an area for improvement.

6.2.5 Infection prevention and control measures

We found that there was an adequate supply of personal protective equipment (PPE) at the entrance to the home and PPE stations were well stocked throughout the East and West Wing. On discussion with staff they advised that management were very proactive in ensuring there was a good supply of PPE. Although there was an adequate supply of PPE, hand sanitising gel was limited within corridor areas of the home. The manager advised that a number of dispensers had been transferred to other areas within the home in response to COVID-19, but agreed to continue to monitor the need for additional dispensers where necessary.

Staff spoken with were knowledgeable regarding the symptoms of Covid-19 and how to escalate any changes in a patient's usual presentation to the person in charge. Staff also said that if they themselves felt unwell, they would inform the person in charge and isolate, at home, as per regional guidance.

We were advised by staff that temperature checks were being completed on all patients and staff twice daily and that any concerns or changes were reported to the manager and/or nurse in charge.

We discussed the provision of mandatory training specific to IPC measures with staff. Staff confirmed that they had access to online training and that the training provided them with the necessary skills and knowledge to care for the patients. Training records confirmed that staff had completed IPC training and that management were monitoring progress with overall mandatory training to ensure full compliance.

Despite IPC training having been completed a number of deficits were identified during the inspection. Clean towels were observed on top of an unclean linen trolley, used razors were observed in a number of patient bedrooms in a container with a toothbrush, staining was evident on a number of bed linen and socks/tights were identified in a linen store for communal use. We further asked staff how hoist slings are decontaminated between each patient and were advised that they are washed weekly or more often if required but that there was no documented system for decontaminating slings between patients. A number of over bed tables were also observed as damaged and light pull cords in identified bathrooms were not effectively covered. The IPC issues were discussed in detail with the manager and an area for improvement was made.

6.2.6 Environment

On review of the environment a number of unnecessary risks to patients with dementia were identified. For example, scissors were identified in a patient's bedroom within an unlocked drawer; razors were unsecure within patients' bedrooms; razors and air freshener spray were also accessible in an unlocked store. The hair dressing room which had temporarily been changed to a staff room within the East Wing was unlocked with access to equipment such as a kettle, toaster and hair colouring products. This was brought to the attention of available staff who immediately secured the door. This was discussed with the manager who acknowledged the importance of securing the items detailed above and an area for improvement was made.

Further concerns were identified in regards to the potential ligature risks associated with window blinds at a fire exit door within the East Wing. We were also concerned that window blinds at fire exit doors may present as a potential obstacle in the event of a fire and requested that the manager liaise with the fire risk assessor. Following the inspection the manager advised that the window blinds had been removed to these exit doors. The manager was made aware of the urgent need to review all window dressings to assess any potential risks and to ensure patients safety. This was identified as an area for improvement in relation to current health and safety guidelines.

We observed an identified fire exit door on a number of occasions throughout the inspection as unsecure, with the potential risk to patients' safety due to the possibility of unauthorised access to the building. This was discussed in detail with the manager and identified as an area for improvement.

A number of unoccupied bedrooms throughout the home were being used as temporary staff storage, dining and staff areas. The manager advised us that this was a temporary measure due to current COVID-19 restrictions. We discussed the importance of the rooms being used for the purpose that they were registered and requested written information regarding the location of the rooms and that this was a temporary measure during the COVID-19 pandemic. Following the inspection, this information was received in writing from the manager.

6.2.7 Leadership and management arrangements

Since the last inspection there has been no change in management arrangements. A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded.

A number of governance audits were reviewed in relation to the environment, IPC and care records which did not capture the issues identified during inspection. Hand hygiene and PPE compliance audits were identifying deficits which were evident by the overall percentage figure; however, the rationale for the deficit was not documented and there was no action plan to address the issues. We further identified that the environmental audits did not contain the location within the home where deficits had been identified. In order to drive the necessary improvements an area for improvement was made.

Discussion with the manager and review of records evidenced that quality monitoring visits were completed on a monthly basis and copies of the report were available for patients, their representatives, staff and trust representatives. Although the reports documented that audits had been carried out, they failed to fully identify the issues that were evident during the inspection in relation to the environment and deficits in IPC. Following the inspection a discussion was held with the regional manager Patricia Greatbanks regarding the findings of the inspection who agreed to liaise with the manager and provide the necessary support to address the issues detailed within this report.

Written confirmation was received on 30 July 2020 from the manager detailing immediate action that had been taken to address the issues identified during the inspection, followed by an action plan on the 3 August 2020 detailing the measures that were implemented to address all deficits going forward, to improve the delivery of safe and effective care within the home.

Areas for improvement

Ten new areas were identified for improvement. These were in relation to: staffing arrangements, care delivery, pressure area care, delivery of meals, care records, IPC, risk management, ligature risk, security of the home and quality governance audits.

	Regulations	Standards
Total number of areas for improvement	4	6

6.3 Conclusion

There was evidence that staff were knowledgeable regarding the needs of patients and how to access relevant services in response to the needs of patients. We were satisfied that the appropriate action had been taken to address any immediate issues identified during the inspection and that an action plan had been developed to address all deficits going forward.

7.0 Quality improvement plan

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Tracey Palmer, 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 13 (1) (a) (b) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the nursing, health and welfare of patients is in accordance with their planned care and the recommendations of other health care professionals. This is in specific reference to care plans and daily records: • accurately reflect the frequency of repositioning • contain clear information regarding the recommended type of hoist and sling • contain clear information regarding patients' recommended daily fluid intake • accurately reflect the level of assistance required with personal care • accurately reflect the level of assistance with mobility and equipment required • contain clear information regarding medical conditions where treatment is being provided • where a patient has a history of weight loss the care plan accurately states the frequency of monitoring the patients weight. Ref: 6.2.4
	Response by registered person detailing the actions taken: The identified issues were discussed with all Registered Nurses and supervision on record keeping and documentation was commenced. Registered Manager will monitor compliance.
Area for improvement 2 **Ref:** Regulation 13 (7) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that the environmental and infection prevention and control issues identified during this inspection are urgently addressed and a system is initiated to monitor ongoing compliance. Ref: 6.2.5
	Response by registered person detailing the actions taken: Issues identified during inspection have been addressed. Supervisions have commenced on infection control. Spot checks are completed by Nurse in Charge and should any deficits be noted, same is then discussed at flash point meetings. Registered Manager monitoring compliance.

Area for improvement 3 **Ref:** Regulation 27 (2) (t) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall, having regard to the number and needs of the patients, ensure that a risk assessment to manage health and safety is carried out and updated when necessary. With specific reference to safe storage of: • scissors and razors • kettle and toaster • hair colouring products Ref: 6.2.6
	Response by registered person detailing the actions taken: All actioned on the day of inspection. Hairdressing cupboards have also had locks fitted. Registered Manager will monitor compliance.
Area for improvement 4 **Ref:** Regulation 27 (2) (t) **Stated:** First time **To be completed by:** With immediate effect	The registered person shall, having regard to the number and needs of the patients, ensure that a risk assessment to manage health and safety is carried out and updated when necessary. With specific reference to window blinds. Ref: 6.2.6
	Response by registered person detailing the actions taken: This has been reviewed by FSHC Health & Safety Advisor 31.07.20, correspondence sent to Inspector. Blinds have subsequently been removed.
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes, April 2015	
Area for improvement 1 **Ref**: Standard 41 **Stated:** First time **To be completed by:** With Immediate effect	The registered person shall ensure that the patient dependency levels are kept under review to ensure staffing arrangements in the home meet patients' assessed needs. Ref: 6.2.1
	Response by registered person detailing the actions taken: Staffing levels are reviewed at least monthly using CHESS. Registered Manager will monitor indicative staffing.

Area for improvement 2 **Ref**: Standard 6 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that patients' personal care and grooming needs are regularly assessed and met. This includes (but is not limited to): • Patient's finger nails • Facial hair • Footwear • Clothing Ref: 6.2.2
	Response by registered person detailing the actions taken: Following inspection new daily care sheets have been implemented. Registered Nurses also spot check residents personal hygiene and presentation on a daily basis. The Home Manager also monitors and records on daily walkabout spot check weekly.
Area for improvement 3 **Ref**: Standard 23 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure that there are clear and documented processes for the prevention, detection and treatment of pressure damage. With specific reference to ensuring: • that the settings on pressure relieving mattresses are maintained at the correct setting and included in the patients care plan. Ref: 6.2.2
	Response by registered person detailing the actions taken: Manufacturers information on mattress settings were collated and covered under supervision with staff who now have a better understanding that settings are adjusted as per resident weight. Staff were also advised that Auto Logic do not have settings as they are self adjusting. Care Plans now detail the type of mattress and required setting where applicable. Should a resident choose to have the mattress at a different setting, this too will be recorded.
Area for improvement 4 **Ref**: Standard 12 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall review the transportation of meals to patients' bedrooms to ensure they are covered and placed in an appropriate area. Ref: 6.2.2
	Response by registered person detailing the actions taken: Dining experience audits have been completed which included a review of how meals were transported to residents bedrooms. Findings of audits shared with staff under supervision. Training planned includes IDDSI and Dining Experience.

Area for improvement 5 **Ref:** Standard 44.5 **Stated:** First time **To be completed by:** With immediate effect	The registered person shall ensure security measures are operated that restrict unauthorised access to the home to protect patients and their valuables, the premises and their contents. With specific reference to the use of an identified fire exit door. Ref: 6.2.6
	Response by registered person detailing the actions taken: This was reviewed by FSHC Health & Safety Advisor 31.07.20, correspondence was forwarded to Inspector. The area now has a keypad fitted.
Area for improvement 6 **Ref**: Standard 35 **Stated:** First time **To be completed by:** 29 August 2020	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. • Environmental and hand hygiene audits should be sufficiently robust to ensure that any IPC deficits are appropriately identified and actioned • Governance audits in respect of care records to ensure care plans and care records are maintained as required Ref: 6.2.7
	Response by registered person detailing the actions taken: Environmental and hand hygiene audits have been completed as per schedule. No identified issues have been raised with regards to hand hygiene. Deficits arising from quality assurance audits shall be shared with staff and action plan shall be updated closing the loop until all areas are addressed.

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

The Regulation and Quality Improvement Authority

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