The Regulation and Quality Improvement Authority

Inspection Report

15 June 2021

Seapatrick

Type of service: Nursing Home
Address: 80 Lurgan Road, Seapatrick, Banbridge, BT32 4LY
Telephone number: 028 4062 8289

Information on legislation and standards underpinning inspections can be found on our

1.0 Service information

Organisation/Registered Provider: Four Seasons Health Care **Registered Individual:** Mrs Natasha Southall	**Registered Manager:** Mrs Shily Paul **Date registered:** 18 January 2021
Person in charge at the time of inspection: Mrs Shily Paul	**Number of registered places:** 60
Categories of care: Nursing Home (NH) I – Old age not falling within any other category DE – Dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH – Physical disability other than sensory impairment.	**Number of patients accommodated in the nursing home on the day of this inspection:** 56
Brief description of the accommodation/how the service operates: This home is a registered Nursing Home which provides nursing care for up to 60 patients. The home is divided into three units, all located on the ground floor. Two of the units provide care for people with dementia or mental disorder and the third unit provides care to people with physical disability.	

2.0 Inspection summary

An unannounced inspection took place on 15 June 2021 from 8.45 am to 3.45 pm, by a care inspector.

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

All areas for improvement identified on the last inspection were reviewed and met.

The home was found to be clean, tidy, well-lit, warm and free from malodour.

Staffing arrangements were found to be safe, effective and adjusted if/when required following regular review. Staff were seen to be professional and polite as they conducted their duties and told us that they were supported in their roles with training and resources.

Patients were seen to be well looked after. There was clear evidence of attention to personal care and dressing and those patients who required assistance with mobility, changing position and completing meals where seen to be attended to by staff in a prompt and compassionate manner.

Patients expressed positive opinions about the home and the care provided. Patients said that staff were helpful and pleasant in manner, that they were satisfied with the food provided, and that they could choose how they spent their time.

There were systems in place to enhance communication between management, staff and patients in the form of various meetings. It was suggested that patient meetings would benefit from a more structured agenda with recurring topics in addition to any topics the patients wished to raise. The manager agreed to review this. Arrangements for meetings will be reviewed at the next inspection.

Feedback from patients, staff, relatives and professional visitors indicated that they were very satisfied with the care and service provided at Seapatrick.

RQIA were assured that the delivery of care an services provided in Seapatrick was safe, effective, and compassionate and that the service was well led.

The findings of this report will provide the management team with the necessary information to further 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.

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 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 was observed and how staff went about their work.

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 Shily Paul, Manager at the conclusion of the inspection.

4.0 What people told us about the service

Twelve patients, ten staff and two professional visitors were spoken with during the inspection. RQIA received questionnaires completed by eight patients and four relatives following the inspection.

Patients told us that they were satisfied with the service in the home. They described staff as "good" and "great" and the majority of patients said that there was enough staff available and that they get help and assistance when they need it. One patient said that while staff were nice, they felt that staff were so busy at times that they could not provide assistance in a timely manner. This patient's expression of concern was discussed in detail with staff and the manager and assurances were provided that all efforts were made to attend to this patient's wishes. Observation during the inspection indicated that this patient's needs were met.

Patients said that they were happy with the environment and were complimentary about the meals, with some describing the food as "very good", and others telling us that they looked forward to the meal times and that they got plenty of cups of tea and snacks between main meals.

Patients told us that they could choose how they spent their time, with some describing participating in organised activities and others saying that they enjoyed occupying their own time with television, listening to music, reading, or relaxing in the garden in good weather. One patient talked about how, as part of their usual pattern, they would often be awake and up at night but this was not an issue in relation to the home's routine and staff accommodated them.

Patients told us that they could avail of visits from family and friends and enjoyed connections with the community. Comments included, "getting out is important to my health", "this is my life line and helps with my mental health".

Relatives indicated through the questionnaires that they were very satisfied that the care was safe, effective, and compassionate and the service was well led.

Two professional visitors to the home said that they had no concerns during their visits and described the home as a "nice place".

One staff member informed us that there had been a recent issue with the supply of a particular product. On discussion with the manager RQIA were satisfied that this had been well managed and had not impacted on service provision.

Staff said that they were kept informed through patient information handover meetings at the start of each shift or quick departmental meetings most mornings. Staff were conversant in relation to how to raise concerns and who they could go to. They said that they felt comfortable in approaching the manager, deputy manager or nurse in charge at any time and felt confident that concerns would be addressed. Further comments received from patients and staff are included in the main body of this report.

5.0 The inspection

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

Areas for improvement from the last inspection on 1 and 2 December 2020		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 39.9 **Stated:** First time	The registered person shall ensure that all staff have completed training in relation to the Mental Capacity Act (NI) 2016 and Deprivation of Liberty Safeguards (DoLS), to a level appropriate to their role and responsibilities. All staff should complete training to level 2 and have a general awareness and understanding of deprivation of liberty. Staff with direct responsibilities in caring for patients who may be deprived of their liberty, pre-admission assessments and taking charge of the home should complete training to level 3.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met with Mental Capacity Act (NI) 2016 and Deprivation of Liberty Safeguards (DoLS) training now added to the mandatory training schedule.	

<table>
<tr><td rowspan="2">Area for Improvement 2

Ref: Standard 44.1

Stated: First time</td><td>The registered person shall ensure that all areas of the home are maintained to a hygienic standard to reduce the risk of infection to patients, staff and visitors.

This is with specific reference to:

• The covering of nurse call pull cords to allow for effective cleaning
• Efficient cleaning of undersides of dispensers for soap, hand sanitiser, paper towels and toilet paper.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was evidence that this area for improvement was met. Nurse pull cords were covered and undersides of dispensers were clean.</td></tr>
<tr><td rowspan="2">Area for Improvement 3

Ref: Standard 11

Stated: First time</td><td>The registered person shall ensure that provision of activities is equitable for all patients living in the home.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was evidence that this area for improvement was met.</td></tr>
<tr><td rowspan="2">Area for improvement 4

Ref: Standard 23

Stated: First time</td><td>The registered person shall ensure that individual care records reflect up to date interventions.

This is with specific reference to the documenting of pressure relieving devices in use and the required settings, if applicable.</td><td rowspan="2">Met</td></tr>
<tr><td>Action taken as confirmed during the inspection:
There was evidence that this area for improvement was met.</td></tr>
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5.2 Inspection findings

5.2.1 Staffing Arrangements

Safe staffing begins at the point of recruitment. A sample of staff recruitment files were reviewed and showed that robust systems were in place to ensure staff were recruited correctly to protect patients as far as possible.

All staff were provided with an induction programme relevant to their department and to prepare them for working with the patients. One member of staff who had recently completed their initial induction period described this as a positive experience and said that they felt supported to learn during the induction period and that the learning continued beyond this with regular mandatory training.

There were systems in place to ensure staff were trained and supported to do their jobs. Review of records showed that training comprised of a range of relevant and mandatory topics, with the majority of courses available on an eLearning platform and courses with practical elements delivered face to face. Since the last inspection the majority of staff had completed training on the Mental Capacity Act (NI) 2016 and Deprivation of Liberty Safeguards (DoLS), to a level relevant to their roles.

Staff said that they were adequately trained to conduct their roles and that everyone was aware of their own roles and responsibilities within the team. Staff told us that they had adequate supplies such as cleaning materials and Personal Protective Equipment (PPE), and equipment such as hoists.

Review of governance records provided assurance that all relevant staff were registered with the Nursing and Midwifery Council (NMC) or Northern Ireland Social Care Council (NISCC) and that these registrations were effectively monitored by the manager on a monthly basis.

The duty rotas accurately reflected the staff working in the home over a 24 hour period. The manager's hours and capacity worked were stated on the duty rota and the nurse in charge at each shift in the absence of the manager was highlighted. Staff told us that they knew who was in charge of the home at any given time.

The manager confirmed that safe staffing levels were determined and/or adjusted by ongoing monitoring of the number and dependency levels of patients in the home. It was noted that there was enough staff available in the home to respond to the needs of patients.

Patients told us that staff were "great" and "good" during interactions and the majority of patients said that staff were available to them when needed. One patient said that they felt staff were "so busy" and that this sometimes delayed response times. With the patient's consent this was discussed with the manager who provided further explanation about this patient's care plan and agreed to monitor this patient's satisfaction.

Staff told us that there was enough staff on shift and confirmed that sometimes short notice staff absences were covered by temporary or agency staff. Some staff described an improvement in staffing levels since the last inspection, acknowledging the recruitment of new staff and told us that this strengthened the team. Senior staff described how they supported new staff with inductions and ongoing supervision. Staff conveyed the importance of putting patients' needs first and talked about Seapatrick being the patients' "home" and "not a factory".

One staff member expressed dissatisfaction in relation to recurrent absences of some other staff. This was discussed with the manager who provided assurances that issues relating to recurrent unplanned absences from work were being managed. RQIA were satisfied that appropriate action was taken in relation to this.

Staff were seen to attend to patients' needs in a timely manner and to maintain patient dignity by offering personal care discreetly and ensuring patient privacy during personal interventions. Patients were offered choices throughout the day, from where and how they wished to spend their time, what they ate and drink, what activities they wished to avail of, to what temperature their room was.

Relatives who provided feedback via the questionnaires did not express any concerns in relation to staffing.

In summary, assurances were provided that staffing arrangements in the home were safe and staff conducted their jobs in a professional and polite manner.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of patients. Staff were knowledgeable of patients' needs, their daily routine, likes and dislikes. A diary was maintained on each unit to ensure important daily activities, appointments, or reviews were not missed. Staff confirmed the importance of good communication, not only within their teams but also between departments and the home manager. An example of good communication was noted in the form of a daily 'flash' meeting each morning, which was attended by one person from each department for a quick review of the business for that day.

Staff were seen to provide a prompt response to patients' needs and demonstrated an awareness of individual patient preferences. Staff were observed to be respectful during interactions and to communicate clearly, for example staff were heard to give clear instruction of their intent to patients during interventions and to seek patients' consent.

Patients' needs were assessed 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.

Patients who are less able to mobilise require special attention to their skin care. These patients were assisted by staff to change their position regularly. Care records accurately reflected the patients' needs and if required nursing staff consulted the Tissue Viability Specialist Nurse (TVN) and followed the recommendations they made.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, aids such as alarm mats, crash mats or bedrails were in use, patient areas were free from clutter, and staff were seen to support or supervise patients with limited mobility. Staff also conducted regular checks on patients throughout the day and night. Those patients assessed as being at risk of falling had care plans in place.

Records confirmed that in the event of a patient falling, post falls protocol was followed and there was evidence that staff took appropriate action. There was evidence of appropriate onward referral where required, such as to Occupational Therapy or Trust falls prevention team. Following a fall relevant parties such as next of kin, Trust key worker and where required RQIA were informed. The manager conducted a monthly falls analysis to identify patterns and to determine if any other measures could be put in place to further reduce the risk of falls.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this may include simple encouragement through to full assistance from staff. Breakfast and lunch servings were observed and found to be pleasant, social and unhurried experiences for patients. The food looked and smelled appetising and portion sizes were generous.

There was a variety of drinks available and at least two options of meals at each sitting. Staff were seen to offer the appropriate level of support or assistance where required and patients were offered clothing protectors in a dignified manner. Patients said that the food was good and talked about the different foods on offer during and between meals. A record of patients' food and fluid intake was maintained and nutritional records referenced patients' likes and dislikes.

Patients' weights were monitored at least monthly or more often if recommended by dietetics. Records showed that there was appropriate onward referral to Speech and Language Therapy (SALT) or dietetics, and any recommendations made were detailed in the patients' individual care records.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

Patients spoke in positive terms about the care provided and looked well cared for, in that they were well dressed and attention had been paid to personal care and appearance.

Relative questionnaire responses indicated that they were very satisfied that the care provided was effective and delivered with compassion.

In summary, there were no concerns identified in relation to care delivery and record keeping.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included a sample of bedrooms, communal lounges, dining rooms and bathrooms, and storage spaces. The home was clean, warm, well-lit and free from malodours.

Corridors were clean and free from clutter or inappropriate storage. Fire doors were seen to be free from obstruction. The most recent fire risk assessment was undertaken on 21 August 2020 and records evidenced that any recommendations made had been addressed.

Patients' bedrooms were clean, tidy and personalised with items of importance to each patient, such as family photos, jigsaws and games, radios and sentimental items from home.

Bedrooms and communal areas were found to be well maintained and suitably furnished. Notice boards displayed patients' arts and crafts work.

The enclosed courtyard was well maintained with an even paved ground, raised beds, trees, seating and shaded canopy areas. Patients were seen to come and go from the garden area and enjoy the sunshine.

Measures were in place to manage the risk of COVID-19. There was signage at the entrance of the home reflecting the current guidance and everyone entering the building had their temperature checked and a health declaration completed on arrival. Details of all visitors were maintained for track and trace purposes.

Hand hygiene facilities were available and Personal Protective Equipment (PPE) such as masks were provided to all visitors before proceeding further into the home. Visiting arrangements were in place in keeping with the current guidance and it was positive to note some patients availing of trips out of the home with family.

Staff were seen to practice hand hygiene at key moments and to use PPE correctly. Governance records showed that Infection Prevention and Control (IPC) audits were conducted regularly and monitored staffs' practice and compliance with the guidance.

Domestic staff maintained records of cleaning schedules and told us that they had the staffing and resources to meet IPC standards. Domestic working hours had changed since the last inspection to accommodate a later shift which ended at 6pm. Staff confirmed that care staff continued with some cleaning duties in the absence of domestic staff. All areas of the home were found to be clean.

Patients did not express any concerns about the cleanliness of the home or the facilities available.

In summary, there were effective systems in place to ensure IPC standards were met, and staff, patients and relatives did not express any concerns in relation to the management of the COVID-19 pandemic.

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 some patients preferred to spend time in their bedrooms and some used the communal areas, and some patients were seen to move between communal a personal spaces. One patient described how they didn't like to get involved in group activities but enjoyed more one to one sessions or working alone on arts and crafts projects.

The home had two activities coordinators employed and time was allocated to both the dementia and the general nursing units. Review of the social and recreational records for patients showed that a range of activities were offered on a regular basis and individual records were maintained for each patient.

Patients were consulted on aspects of the home important to them, such as dining, environment and care delivery. Patient consultation records were maintained such as patient meetings and surveys. The most recent patient meeting took place in March 2021 and the minutes were available on inspection. It was noted that while topics such as activities were discussed at the meeting, there was no set agenda. This was discussed with the manager and it was agreed that a more structured agenda with regular recurring topics such as environment, laundry, care and meals would ensure that all relevant topics were explored in addition to topics raised by the patients. A more structured format would also assist those staff chairing the meetings. This will be reviewed at the next inspection.

It was positive to note that a patient menu satisfaction survey had been conducted in November 2020 and that patients' suggestions had been incorporated into the four week menu planner.

As mentioned in section 5.2.3 visiting arrangements were in place and reflective of current Department of Health (DoH) guidance. Patients could avail of up to three indoor visits per week in the comfort of their own bedrooms or take trips out with family.

Patients confirmed that they had regular visits from family. Written information had been sent to all patients' next of kin explaining the DoH Care Partner initiative and a number of relatives availed of this offer. Relevant risk assessments and Care Partner agreements were in place.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff assisted patients to make phone or video calls. Some relatives chose to still do window visiting as their preferred method of contact.

Professional visitors said that they had no concerns with the home and staff were observed to assist professional visitors by escorting them to the patients and providing a professional handover of information.

Staff acknowledged the importance of putting patients' needs and wishes first, with one staff giving the example of some patients preferring a shower later in the day rather than first thing in the morning, and that this is accommodated.

In summary, staff demonstrated an ethos that supported patients to have meaning and purpose to their day.

5.2.5 Management and Governance Arrangements

Staff were aware of who the person in charge of the home was at any given time. Discussions with staff also evidence that they understood their roles and responsibility in reporting concerns or worries about patient care, staffs' practices or the environment.

There had been no changes in the management of the home since the last inspection. Mrs Shily Paul had been appointed as manager in July 2019 and became the registered manager in January 2021.

In addition to the 'flash' meetings mentioned in section 5.2.2 records indicated that regular staff meetings took place. Minutes and attendance lists for all meetings were maintained. One staff member commented that they did not know what was discussed at the meetings if they could not attend. This was discussed with the manager who explained that general staff meeting minutes are posted in the staff room for those who could not attend. The manager agreed to remind all staff of this important communication system.

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.

It was established that the manager had a system in place to monitor accidents and incidents that happened in the home. Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

It was noted that patients and relatives were provided with a written copy of the complaints procedure on admission to the home. There had been no recent complaints made but there was a system in place to manage any expressions of dissatisfaction if required.

It was positive to note that the manager maintained records of compliments received about the home and shared these compliments with staff. One recent thank you card said, "…for the loving care and attention…received…was very happy…enjoyed the chats with staff and other residents…meant a lot to us…we are missing the visits to Seapatrick and the daily phone calls…"

Staff commented positively about the management team and described them as supportive, approachable and always available for guidance. Discussion with the manager and staff confirmed that there were good working relationships.

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 are available for review by patients, their representatives, the Trust and RQIA.

In summary, there were effective systems in place to monitor all aspects of the running of the home. There was a clear organisational structure in place and all staff were aware of their roles within that structure.

6.0 Conclusion

Patients looked well cared for in that they were well dressed, clean and comfortable in their surroundings. Patients who required assistance to change positions were attended to by staff and positioned comfortably.

Patients were seen to express their right to make choices throughout the day; from the care they received to how they spent their time. Staff were observed to be attentive to those patients who were unable to verbally express their needs.

Patients' privacy and dignity were maintained throughout the inspection and staff were observed to be polite and respectful to patients and each other.

Patients, staff, relatives and professional visitors did not express any concerns about the service.

Based on the inspection findings and discussions held we are satisfied that this service is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the management team.

7.0 Quality Improvement Plan/Areas for Improvement

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

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

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

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