Inspection Report

19 September 2023

Seapatrick

Type of service: Nursing Home
Address: 80 Lurgan Road, Seapatrick, Banbridge, BT32 4LY
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Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation/Registered Provider: Ann's Care Homes **Responsible Individual** Mrs Charmaine Hamilton	**Registered Manager:** Mrs Shily Paul **Date registered:** 18 January 2021
Person in charge at the time of inspection: Mrs Shily Paul	**Number of registered places:** 60 A maximum of 38 patients in category NH-DE located in the Dementia Unit and a maximum of 22 patients located in the General Unit. There shall be a maximum of 1 named patient in category NH-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:** 57
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care to up to 60 patients. The home is divided into three units all located on the ground floor. Riverdale and Bannview units provide care for patients with dementia and Meadowlands unit provides general nursing care**.**	

2.0 Inspection summary

An unannounced inspection took place on 19 September 2023 from 9.30 am to 4.35 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.

An unannounced medicines management inspection also took place on 19 September 2023, from 9.50 am to 1.50 pm. This was completed by two pharmacist inspectors. The purpose of the inspection was to assess if the home was delivering safe, effective and compassionate care and if the home was well led with respect to medicines management.

The home was clean, warm, well-lit, free from malodour, and there was a welcoming atmosphere.

Staff were seen to conduct their duties in a warm and professional manner and to address patients' needs in a timely way and with compassion.

Patients looked well cared for, in that staff had paid attention to personal care and dressing needs. Patients told us that living in Seapatrick was a positive experience, and those patients unable to voice their opinions fully were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

It was positive to note that visiting arrangements were in place and working well and that relatives could visit with their loved ones at any time during the day.

We found that there was safe, effective and compassionate care delivered in the home and the home was well led. Previously identified areas for improvement were reviewed and assessed as met. No new areas for improvement were identified in relation to care.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicine records and medicine related care plans were well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. Based on the inspection findings and discussions held, RQIA 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 with respect to medicines management.

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 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 Mrs Shily Paul, manager, at the conclusion of the inspection.

4.0 What people told us about the service

Patients told us that they were happy with the care and services provided in the home. Patients were complimentary about staff, with comments such as “they are wonderful and do a great job”, and “staff are very good and caring.”

Patients said that they were satisfied with the environment and facilities and told us that they were happy with the level of cleanliness. Patient confirmed that staff supported them to choose how and where they spent their day and that they had a variety of food and drinks available to them.

Relatives told us that they were very satisfied with the care and services in the home and that the home was well led. Comments from relatives included, “staff are friendly”, “staff are brilliant”, “visiting is great…we can come every day”, and “the place is always clean.”

Staff spoke positively about working in Seapatrick and told us that they felt supported through training and regular team meetings. Some nursing staff said that they would like to avail of more training above the mandatory training provided by the home. Staff views were discussed with the manager who provided assurances that staff are supported to undertake any training relevant to their role.

Staff said that there was good teamwork in the home and that new staff were supported through induction programmes and “buddy” systems.

Two completed questionnaires were received from patients after the inspection. Both indicated that they were very satisfied that the care provided in Seapatrick was safe, effective, delivered with compassion, and that the service was well led. They included comments that staff were “very good.”

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 30 January 2023		
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)		**Validation of compliance**
Area for improvement 1 **Ref:** Standard 38.3 **Stated:** First time	The registered person shall ensure that before staff commence working in the home that the required pre-employment checks are received and reviewed in accordance with relevant statutory employment legislation and mandatory requirements.	**Met**

	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 **Ref:** Standard 46 **Stated:** First time	The responsible person shall ensure that staff are aware of their responsibilities regarding maintaining effective IPC measures and the use of PPE. The system in place to monitor the use of PPE should be effectively robust to identify and address deficits in these areas.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

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. It was positive to note that staff could access a suite of essential training courses online prior to starting work in the home.

Staff were provided with a comprehensive induction programme at the commencement of their employment and staff confirmed that new staff were “buddied up” with more experienced staff to help them become familiar with the policies and procedures in the home.

Appropriate checks had been made to ensure that registered nurses maintained their registration with the Nursing and Midwifery Council (NMC) and care workers with the Northern Ireland Social Care Council (NISCC) with a record maintained by the manager of any registrations pending or actions taken.

There were systems in place to ensure staff were trained and supported to do their job. The manager had good oversight of staffs’ compliance with mandatory training and confirmed that as well as the essential courses provided through the home’s eLearning system and practical courses, additional training was also often sourced via the Trust. Staff said that they were happy with the training provided and some nursing staff said that they would be open to more training if it was available. Comments were shared with the manager for consideration and action if appropriate.

Staff said there was good team work and that they felt well supported in their role, and were satisfied with the staffing levels and the level of communication between staff and management.

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. Any nurse taking charge of the home in the absence of the manager had a competency assessment completed to ensure they had the knowledge and skills necessary.

It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way, and staff, patients, and relatives said that they were satisfied with staffing arrangements.

5.2.2 Care Delivery and Record Keeping

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs. For example, with a patient who was showing early indications of becoming upset due cognitive issues associated with dementia, staff were seen to use distraction techniques to divert the patient on to topics that had positive associations for the patient. This was done in a discreet and reassuring manner.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, bed rails and/or alarm mats. It was established that safe systems were in place to manage this aspect of care.

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. In addition, patient care records were maintained which accurately reflected the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner, and by offering personal care to patients discreetly.

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.

Care records were well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, specialist equipment such as alarm mats were used, or there was increased supervision from staff.

Examination of records confirmed that the risk of falling and falls were well managed. There was evidence of appropriate onward referral as a result of the post falls review. For example, patients were referred to the Trust's Specialist Falls Service, their GP, or for physiotherapy.

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.

The dining experience was an opportunity of patients to socialise, music was playing, and the atmosphere was calm, relaxed and unhurried. It was observed that patients were enjoying their meal and their dining experience. Staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

There was choice of meals offered, the food was attractively presented and smelled appetising and portions were generous. There was a variety of drinks available.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. If required, records were kept of what patients had to eat and drink daily.

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.

5.2.3 Management of the Environment and Infection Prevention and Control

The home was clean, warm, and comfortable.

Patients' bedrooms were clean, tidy and personalised with items of importance or interest to the patient. Communal lounges and dining rooms were suitably furnished and comfortable.

Patients and relatives told us that they were very satisfied with the level of cleanliness in the home.

Communal toilets and bathrooms were clean and accessible. It was noted that there was some inappropriate storage of supplies in the hairdressing room. This was highlighted to the manager and the supplies were removed immediately to a more appropriate location. The manager provided assurances that they would conduct a review of all current storage areas and remind all relevant staff about storage arrangements.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Staff were aware of their training in these areas and how to respond to any concerns or risks.

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, observations and discussions with staff confirmed that there was ample supply of personal protective equipment (PPE) and cleaning supplies and any outbreak of infection was reported to the Public Health Authority (PHA).

Review of records, all staff had completed training on infection prevention and control (IPC) measures and the correct use of PPE.

One staff member was seen to wear a bracelet and stone ring. This is not conducive to best practice in hand hygiene or patient moving and handling. This was brought to the attention of the manager for their action. All other staff were bare below the elbows and were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept.

5.2.4 Quality of Life for Patients

Observation and discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV. It was observed that staff offered choices to patients throughout the day which included food and drink options and where and how they wished to spend their time.

Patients' social and recreational needs were met through a range of individual and group activities. The range of activities included social, community, cultural, religious, spiritual and creative events. Examples of organised sessions during the week of the inspection were, bingo, board games, arts and crafts, cupcake decorating, movies and a church service.

On the morning of inspection patients were seen to take part in cards games, listen to music, read, watch television and enjoy chats with staff or visitors. In the afternoon patients enjoyed a session with 'visiting creatures' that they could pet.

There was a homely and relaxed atmosphere in the home throughout the day.

Visiting arrangements were in place and relatives confirmed that this was working well.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mrs Shily Paul has been the manager in this home since 18 January 2021.

There was a clear managerial structure in place and staff were aware of who was in charge of the home at any given time. Staff demonstrated a good understanding of their roles and responsibilities in relation to reporting concerns or worries about patient care, staffs' practices, or the environment.

The manager held regular flash meetings with staff depending on the activities and needs in each department. Records showed regular general staff meetings took place and records were well maintained and made available to staff if they were unable to attend a meeting.

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, and their care manager. Review of recent incidents showed a pattern of delayed reporting to RQIA. This was discussed with the manager who agreed to review the arrangements for reporting to RQIA under regulation 30. This will be monitored closely by RQIA and action taken if required.

There was evidence that the manager ensured that complaints were managed correctly and that good records were maintained.

Patients and their relatives said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

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.

5.2.6 Medicines Management

The audits completed at the inspection indicated that the medicines were being administered as prescribed.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments. The personal medication records reviewed at the inspection were generally accurate and up to date. In line with best practice, a second nurse had checked and signed the personal medication records when they were written and updated to state that they were accurate. However, discrepancies in two medicine doses were drawn to the attention of the manager and nurse for remedial action.

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment. A sample of the medicines administration records was reviewed. The records were found to have been fully and accurately completed.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

The medicines storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. A medicine refrigerator and controlled drugs cabinet were available for use as needed.

Satisfactory arrangements were in place for the safe disposal of medicines.

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another. A review of records indicated that mostly satisfactory arrangements were in place to manage medicines for new patients or patients returning from hospital. For three of the four patients whose records were examined, written confirmation of the patient's medicine regime was obtained at or prior to admission. However, for one patient this information had not been obtained. This omission was drawn to the attention of the manager and nurse for remedial action. The medicine records had been accurately completed.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care plans are in place to direct staff on when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient. The management of medicines prescribed on a "when required" basis for the management of distressed reactions was reviewed for seven patients. Directions for use were clearly recorded on the personal medication records and care plans directing the use of these medicines were in place. Staff knew how to recognise a change in a patient's behaviour and were aware of the factors that may be responsible. Records included the reason for and outcome of each administration.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care plans and pain assessments were in place and reviewed regularly.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care plans detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient. The management of thickening agents was reviewed for five patients. For each patient, a speech and language assessment report and care plan was in place. Records of prescribing and administration which included the recommended consistency level were maintained. However, for one patient the thickener consistency level was not recorded on their personal medication record; this was drawn to the attention of the manager and nurse for remedial action.

Care plans were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was too low or too high.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care plans. Written consent and care plans were in place when this practice occurred.

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that staff are competent in managing medicines and that they are supported. There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on all medicines so that they could be easily audited. This is good practice.

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust audit system will help staff to identify medicine related incidents. Management and nurses were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Shily Paul, Manager.

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