The Regulation and Quality Improvement Authority

Inspection Report

3 August 2023

Sanville

Type of service: Nursing Home
Address: 17b Annagher Road, Coalisland, Dungannon, BT71 4NE
Telephone number: 028 8774 8005

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/

1.0 Service information

Organisation: Abbey Private Nursing Home Ltd **Responsible Individuals:** Mrs Alice McAleer	**Registered Manager:** Ms Eilis Bell **Date registered:** 14 July 2023
Person in charge at the time of inspection: Ms Eilis Bell	**Number of registered places:** 40 Including a maximum of one patient within category NH-LD/LD(E) and two patients within category NH-MP/MP(E). There shall be a maximum of five patients in category NH-DE. The home is also approved to provide care on a day basis for one person.
Categories of care: Nursing (NH): I – old age not falling within any other category PH – physical disability other than sensory impairment DE – dementia MP – mental disorder excluding learning disability or dementia MP(E) - mental disorder excluding learning disability or dementia – over 65 years LD – learning disability LD(E) – learning disability – over 65 years	**Number of patients accommodated in the nursing home on the day of this inspection:** 40
Brief description of the accommodation/how the service operates: This home is a registered nursing home which provides nursing care for up to 40 patients. Patients' bedrooms are located over two floors and patients have access to communal lounges, dining rooms and a garden space.	

2.0 Inspection summary

An unannounced inspection took place on 3 August 2023 from 9.25am to 5.20pm 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.

Patients were well presented in their appearance and spoke positively when describing their experiences of living in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients, relatives and staff are included in the main body of this report.

Staff promoted the dignity and well-being of patients and were knowledgeable and well trained to deliver safe and effective care. There was a good working relationship between staff and management.

No areas for improvement were identified from this inspection. RQIA was assured that the delivery of care and service provided in Sanville was safe, effective and compassionate and that the home was well led.

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 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 the manager and the operational manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with patients, relatives and staff. Patients spoke positively on the care that they received and on their interactions with staff. One told us, "The staff are very very good; so kind". Staff were confident that they worked well together and enjoyed working in the home and interacting with the patients. Relatives described the care as, 'excellent'.

There were no questionnaire responses received and we received no feedback from the staff online survey.

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 27 September 2022		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 30 **Stated:** First time	The registered person shall ensure that the medicine refrigerator temperature is maintained within the required range of 2-8^{o}C.	**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

Staff were recruited safely ensuring all pre-employment checks had been completed and verified prior to the staff member commencing in post. All staff were provided with a comprehensive induction programme to prepare them for working with the patients. Staff shadowed a more experienced staff member for, at minimum, one week to become more familiar with the homes policies and procedures. An induction booklet was completed to capture the areas covered during the induction.

Agency staff received an induction to the home prior to commencing their first shift. Agency induction forms were completed and a copy retained in the home. Agency profiles were sent from the agency to the home to validate the staff member's training and included a photograph of the staff member to be used when checking their identification on entry to the home.

There were systems in place to ensure staff were trained and supported to do their job. For example, staff received regular training in a range of topics such as adult safeguarding, infection prevention and control (IPC), patient moving and handling and fire safety. A system was in place to ensure staff completed their training and evidenced that the majority of staff had achieved compliance with this. A new electronic training platform had been introduced in May 2023 and all staff were renewing all mandatory training from this platform.

Staff confirmed that they were further supported through staff supervisions and appraisals. A system was in place to ensure that staff received, at minimum, two supervisions and an appraisal conducted annually.

Checks were made to ensure that nursing staff maintained their registrations with the Nursing and Midwifery Council and care staff with the Northern Ireland Social Care Council.

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Staff raised no concerns regarding the staffing levels and confirmed that patients' needs were met with the number and skill mix of staff on duty. Staff said there was good teamwork in the home. One told us, "It's really good. We all try to help one another out".

The staff duty rota accurately reflected all of the staff working in the home on a daily basis including staff who were providing one to one care. The duty rota identified the nurse in charge of the home in the absence of the manager.

It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through these interactions that the staff and patients knew one another well and were comfortable in each other's company.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. A handover sheet was available to staff containing pertinent details of each patient. An allocation sheet directed staff to where they would be working during the day and with which patients.

Staff were knowledgeable of patients' needs, their daily routine, wishes and preferences. A diary was maintained to ensure important daily activities were not missed such as blood tests or appointments. Staff confirmed the importance of keeping one another up to date with any changing needs in patients' care throughout the day.

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. Assessments and care plans were reviewed regularly to ensure that they were reflective of patients' needs. Patients care records were held confidentially.

All patients had a pressure management risk assessment completed monthly. Where a risk of skin breakdown was identified; a care plan was developed to guide staff in how to manage this risk. Some patients require staff to assist them in repositioning to maintain their skin integrity. Where this was required, records of repositioning had been maintained to identify when they had been repositioned; the position that they had been repositioned to and by whom. These records also evidenced checks which had been made of the patient's skin to ensure that there was no obvious damage observed.

An accident book was completed by staff to record any accidents or incidents which occurred in the home. A review of accident records following a fall in the home confirmed that the correct actions were taken following the accident and the appropriate persons notified of the fall. An accident analysis was completed after any fall in the home to ensure correct actions had been taken.

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 could include simple encouragement through to full assistance from staff. Staff assisted patients throughout the day with food and fluids in an unhurried manner. Staff were knowledgeable in regards to patients' nutritional requirements. Records of patients' intake and outputs were recorded where this was required. There was good availability of food and fluids observed during the inspection. Nutritional risk assessments were carried out monthly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST).

The majority of patients dined together in the dining room during lunch. Tables had been set prior to the meal with tablecloths, condiments, cutlery and flowers. The mealtime was well supervised. There were meal options on the menu for patients to choose from. Alternatives were provided for any patient who did not like either of the options. Staff wore the appropriate personal protective equipment (PPE) and patients, who required, wore clothing protectors to maintain their dignity. The food served appeared nutritious and appetising. A range of drinks was served with the meal. Staff sat alongside patients when providing assistance with their meals. There was a calm atmosphere in the dining room and patients spoke positively on the mealtime experience.

Patients' individual likes and preferences were reflected throughout the records. Daily records were kept of how each patient spent their day and the care and support provided by staff.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment included reviewing a sample of bedrooms, storage spaces and communal areas such as lounges and bathrooms. The home was warm, clean and comfortable. There were no malodours in the home. Appropriate doors had been locked to prevent patients coming into contact with avoidable hazards.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Corridors were clear of clutter and obstruction and fire exits were also maintained clear. Fire extinguishers were easily accessible.

Patients' bedrooms were personalised with items important to them. Bedrooms and communal areas were well decorated and suitably furnished. Some of the bedrooms were being repainted on the day of inspection. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices.

The nurses' station was located at the open reception area. This could prove difficult for nurses to hold sensitive discussions, for example with general practitioners (GPs), while reviewing patients' care records and in the earshot of passers by. This was discussed with the managers during inspection feedback who agreed to review this arrangement.

Review of records, observation of practice and discussion with staff confirmed that effective training on IPC measures and the use of PPE had been provided. Signage promoting effective hand hygiene and safe use of PPE was displayed throughout the home. Staff use of PPE and hand hygiene was regularly monitored by the manager and records were kept. There were good stocks and supplies of PPE and hand hygiene products. Environmental audits and spot checks were conducted frequently and records maintained.

5.2.4 Quality of Life for Patients

Patients confirmed that they were offered choice and assistance on how they spent their day. Patients confirmed that they could remain in their bedroom or go to a communal room when they requested. One patient told us, "I love it here. I can get up when I want and go for breakfast early or late". Another commented, "I like my room; I can come and go as I please". The relatives consulted told us, "We know xxx is very content here. We are always made feel welcome and are kept up to date with everything".

An activities therapist was employed to oversee activity provision in the home. A programme of activities was available for review. Activities were scheduled for mornings and afternoons and included games, storytelling, poems, bingo, singing, movies, baking, arts and crafts, exercises, reminiscence and pamper days. Time was set aside to assist patients with making facetime calls to loved ones. Activities were conducted as a group and on a one to one basis. Patients had been entertained by external musical guests to the home, such as, The Coalisland Silver Band, a banjo player and a harpist. Parties were organised for birthdays and other special days with family members invited to attend. A large poster was made in the home entitled 'Sanville Family Tree'. Patients were involved in writing their own 'words of wisdom' on leaves to be added to the tree. The poster will be displayed in one of the lounges. Records were maintained well of each patients' engagements with activities.

Staff provided care in a dignified manner. Personal care was delivered discreetly behind closed doors. Rooms which accommodated two patients had privacy curtains in place to protect patients' dignity.

Visiting had returned to pre-covid arrangements. Visits could take place in the patients' preferred visiting areas including their bedrooms. Patients were free to leave the home with relatives if they wished.

5.2.5 Management and Governance Arrangements

Since the last inspection there had been a change in the management arrangements. Ms Eilis Bell has been managing the home since 7 November 2022 and registered as manager with RQIA on 14 July 2023. Discussion with the manager and staff confirmed that there were good working relationships between staff and the home's management team. Staff confirmed that the manager has had a positive impact on the home and described her as 'very approachable' and 'very capable'.

Staff were aware of who the person in charge of the home was in the manager's absence. Staff told us that they were aware of their own role in the home and how to raise any concerns or worries about patients' safety, care practices or the environment. Staff members were aware of who to report their concerns to and who to escalate their concern to if they felt that this was required. Staff demonstrated good knowledge of the organisational structure in the home.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. Areas audited included patients' care records, supplementary care records, patients' weights, wound care, restrictive practice, medicines management, staff training and the environment.

A 24-hour communication sheet was completed by staff to give to the manager and included details of any accidents, incidents, hospital admissions, staffing concerns or professional visitors to the home and any other issues identified during the shift.

Accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA. Falls in the home were reviewed monthly for patterns or trends to see if any further falls could be prevented.

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 and completed reports were available for review by patients, their representatives, the Trust and RQIA. Where improvement actions were required, an action plan was included within the report. The action plan would be reviewed at the subsequent monthly monitoring visit to ensure completion.

A complaint's book was maintained and records included the nature of the complaint and any actions taken in response to the complaint. Cards and letters of compliments were maintained on file. A compliments book was available for visitors to the home to record any compliments they wished to share. The manager confirmed that all compliments received would be shared with the staff.

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 Eilis Bell, Manager and Sharon Loane, Operational Manager, as part of the inspection process and can be found in the main body of the report.

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