Unannounced Care Inspection Report
7 February 2017

Sanville

Service Type: Nursing Home
Address: 17b Annagher Road, Coalisland, Dungannon, BT71 4NE
Tel No: 028 8774 8005
Inspector: Sharon Loane

1.0 Summary

An unannounced inspection of Sanville took place on 7 February 2017 from 10.45 to 16.45 hours.

The inspection sought to assess progress with any issues raised during and 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.

On the day of inspection patients, relatives and staff spoken with commented positively in regard to the care in the home. A review of records, discussion with the home manager and staff and observations of care delivery evidenced that all of the requirements and recommendations made as a result of the previous inspection have been complied with.

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

The term 'patients' will be used to describe those living in Sanville which provides both residential and nursing care.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection were discussed with Alice Mc Aleer, registered person, and Claire Reid, home manager as part of the inspection process and can be found in the main body of the report.

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

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an announced pre-registration care inspection undertaken on 14 June 2016.

There were no further actions required to be taken following the most recent inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Brendan Gervin Alice Mc Aleer	**Registered manager:** See box below
Person in charge of the home at the time of inspection: Claire Reid	**Date manager registered:** Acting Manager– No application yet received
Categories of care: NH-I, NH-PH, RC-I, NH-DE, NH-LD, NH-LD(E), NH-MP(E), NH-MP There shall be a maximum 1 patient within category NH-LD/LD (E) and 2 patients within category NH-MP/MP (E). Category NH-DE for 5 identified patients only. The home is also approved to provide care on a day basis for 1 person.	**Number of registered places:** 41

3.0 Methods/processes

Prior to inspection we analysed the following information:

- 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 quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report

The following methods and processes used in this inspection include the following:

- a discussion with the responsible individual and home manager
- a discussion with staff
- a discussion with patients
- a discussion with patient representatives
- a review of three patient care records
- a review of the staff duty roster
- records of registered nurses Nursing and Midwifery Council (NMC) registration
- records of care staff registration with Northern Ireland Social Care Council (NISCC)
- a review of quality audits
- complaints and compliments
- incident and accident records
- review sample of staff training records

During the inspection, care delivery and care practices were observed and a review of the general environment of the home was undertaken.

A number of staff were consulted during the inspection process including two registered nurses, four care staff; the activities co-ordinator and ancillary staff on duty. In addition, 10 patients were spoken with individually and the majority of others were greeted in smaller groups. The representatives of two patients' were also consulted.

Ten questionnaires were also issued to relatives and staff and five to patients with a request that they were returned within one week from the date of this inspection.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 14 June 2016

The most recent inspection of the home was an announced pre-registration care inspection. A quality improvement plan (QIP) did not result from this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 19 April 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 12 (1) (a) (b) **Stated:** First time	The registered person must ensure that the treatment and care provided to each patient meets their identified assessed needs and reflects their plan of care in relation to the management of pressure and / or wounds.	**Met**
	Action taken as confirmed during the inspection: A review of a care record for a patient receiving treatment and care for wounds and/or pressure damage was undertaken. The review of wound assessment charts and associated documentation evidenced that the dressing regimes had been adhered to and were recorded in line with best practice guidelines. There was evidence that the treatment and care delivered was effective as per the progress and improvement noted of the wounds and/or pressure damage.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref:** Standard 4.9 **Stated:** Second time	The registered person should ensure the following actions are taken where patients are at risk of dehydration: • the total fluid intake for 24 hours is recorded in the patients'' daily progress notes	**Met**
	Action taken as confirmed during the inspection: A review sample of daily progress notes for one identified patient evidenced that registered nurses were recording the total fluid intake for 24 hours within these records. A comparison of information recorded within food and fluid charts and the daily progress notes confirmed the accuracy of the recordings across the records. Entries recorded accurately reflected when food and fluid intake was satisfactory and /or inadequate.	
Recommendation 2 **Ref:** Standard 39 **Stated:** First time	It is recommended that a system is developed and monitored to ensure that staff attend training and mandatory trainings requirements are met.	**Met**
	Action taken as confirmed during the inspection: A staff training matrix was available and included details of all staff employed and areas of training completed. A review of this information identified some gaps indicating that staff had not completed mandatory training requirements. A discussion with the home manager identified the reasons for these shortfalls. For example; no longer employed; on maternity leave and /or bank staff. The home manager was advised that the matrix should be updated to include the rationale for the gaps. The home manager agreed to update the matrix to include this information and also to include the frequency for which training had to be completed as per policy, standards and legislative training requirements.	
Recommendation 3 **Ref:** Standard 23 **Stated:** First time	It is recommended that repositioning charts should contain documented evidence that a skin inspection of pressure areas has been undertaken at the time of each repositioning and the actual positional change is recorded. Records should reflect the care delivered and /or not delivered.	**Met**

	Action taken as confirmed during the inspection: A review sample of repositioning records evidenced that the majority of patients were being repositioned in accordance with their plan of care. Repositioning records were maintained in line with best practice guidelines. Whilst some minor gaps were noted the majority of these records were completed comprehensively. Information recorded included; positional changes; condition of skin and evidence that all potential pressure points had been checked twice daily.	
Recommendation 4 **Ref:** Standard 39 **Stated:** First time	It is recommended that training is provided for staff in relation to the prevention and care of pressure damage and /or wound care based on best practice guidelines, training should include the recording of repositioning charts.	**Met**
	Action taken as confirmed during the inspection: A review of training records and discussion with registered nurses on duty confirmed that training had been provided in regards to prevention and care of pressure damage and/or wound management. As discussed earlier, a review of care records pertaining to this area of practice evidenced that the learning had been embedded into practice. A review sample of repositioning records evidenced that the majority of patients were being repositioned in accordance with their plan of care. Repositioning records were maintained in line with best practice guidelines.	
Recommendation 5 **Ref:** Standard 22.10 **Stated:** First time	It is recommended that the monthly accident/incident analysis is further developed to ensure any patterns, trends or shortfalls are identified and to be assured that the necessary improvements required are embedded into practice.	**Met**
	Action taken as confirmed during the inspection: A review of quality audits evidenced that falls analysis was completed on a monthly basis. The analysis included any patterns and/or shortfalls identified in regards to falls management. An action plan was devised and there was evidence that the areas for improvement had been reviewed to ensure quality improvement.	

4.3 Inspection findings

4.3.1 Care delivery and practice

The use of restraint and/or restrictive practice was reviewed in regards to one identified patient. Policies and guidance information to include "Let's Talk about Restraint"; (RCN) were available to guide and direct staff and ensure that practices were based on same. A care plan was available and outlined the parameters for the use of same. A record was available to evidence when the restrictive practice was being implemented. Written evidence was available to confirm that the patient's representatives had been involved and participated in the process. However, no evidence was available within the care records examined of any multi-disciplinary involvement and a minutes of a care review held also did not reference this care intervention. A discussion with the home manager and registered nurses on duty provided assurances that the process had involved all relevant personnel. The home manager advised that they would contact the care manager post inspection and request that information was shared with RQIA to evidence the decision making process for same. RQIA can confirm that this information has been received and reviewed as satisfactory.

A review of a care record for a patient recently admitted to the home was undertaken. A plan of care based on the pre-admission information and referral information was in place. Risk assessments and a detailed plan of care had been completed within five days of the patient's admission to the home. There was evidence that the care plan had been developed in partnership with the patient and/or their representatives.

4.3.2 Consultation

Patients spoken with commented positively with regard to the care they received and were happy in their surroundings. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect and in a timely manner. It was evident from staff and patient engagements that they knew each other well and the majority of the patients spoken with knew the senior management team and the home manager.

Discussions with patients demonstrated that a varied programme of activities was organised and provided by the home. Some patients spoken with discussed recent activities held to celebrate significant calendar events and advised that these were enjoyed by all and enabled them to maintain contact with family, friends and the community. Patients, relatives and staff spoken with advised that senior management representatives visited the home on a daily basis and took an interest in the lives of those living and working in Sanville. This is commended.

During the inspection we met with a number of patients; staff and relatives.

Some comments received from patients are detailed below:
"I've been treated wonderfully by everyone."
"The home provides me with friendship, care and good food."
"This is a brilliant home and staff all very good."

Two relatives spoken with were complimentary regarding the care, staff and management.

We also issued questionnaires as outlined in section 1.1 to gain additional feedback from patients; staff and patients representatives. No questionnaires were returned by patients. Four staff and three relatives returned their questionnaires within the identified timeframe. All respondents indicated that they were "very satisfied" that the care was safe, effective and compassionate and the home was well led.

Additional written comments received from staff include;
"I feel the home is 'a home' for the residents. Staff have a good rapport with both residents and relatives."
"Sanville is a team – The nurses make sure we know everything about the residents."

Additional written comments received from relatives include;
"First class, very well treated, brilliant manager."
"An excellent home in all aspects."

4.3.3 Staffing

The home manager confirmed the planned daily staffing levels for the home and that these levels were subject to regular review to ensure the assessed needs of the patients were met. A review of the staffing roster for weeks commencing 6 February 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients, relatives and staff evidenced that there were no concerns regarding staffing provision within the home.

4.3.4 Environment

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The home was found to be clean, tidy, warm and comfortable. Appropriate actions had been taken in regards to issues identified at the previous care inspection in April 2016. A floor covering in an identified bathroom on the first floor was observed as damaged. This matter was brought to the attention of the home manager and senior management team who advised that the floor covering was due to be replaced on the day following the inspection and also that other refurbishment and redecorations were scheduled to commence the same week. This information was acknowledged by the inspector.

4.3.5 Governance and management arrangements

The home manager has been in post since March 2016. A discussion was held with the senior management team in regards to their plans for the permanent management arrangements for Sanville. Information provided by those spoken with confirmed that an application would be submitted to RQIA for Claire Reid, as registered manager.

A discussion with the home manager and a review of records evidenced that a suite of auditing systems had been developed and implemented. A number of audits had been undertaken since the last inspection, these included but not limited to; wound care; accident and incidents; complaints; and care plans. A review of the above audits evidenced that an action plan had been developed for areas of improvement. There was also evidence that the areas for improvement had been re-audited to check compliance to ensure quality improvement.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

There were no issues identified during this inspection, and a QIP is neither required, nor included, as part of this inspection report.

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 registered provider from their responsibility for maintaining compliance with the regulations and standards.

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