The Regulation and Quality Improvement Authority

Inspection Report

10 December 2021

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

Registered Provider: Sanville **Responsible Individuals:** Mr Brendan Gervin Mrs Alice McAleer	**Registered Manager:** Mrs Ciara Cochrane - Acting **Date registered:** Not registered
Person in charge at the time of inspection: Mrs Ciara Cochrane	**Number of registered places:** 40 There shall be a maximum 1 patient within category NH-LD/LD(E) and 2 patients within category NH-MP/MP(E). There shall be a temporary increase in category NH-DE for 5 non-identified persons and 1 identified patient. This must revert to 5 non-identified persons only when any one of these patients leave the home and RQIA must be notified. The home is also approved to provide care on a day basis for 1 person
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. LD – Learning disability. LD(E) – Learning disability – over 65 years. MP(E) - Mental disorder excluding learning disability or dementia – over 65 years. MP – Mental disorder excluding learning disability or dementia. DE – Dementia.	**Number of patients accommodated in the nursing home on the day of this inspection:** 39
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 in the home and patients have access to communal lounges and dining rooms.	

2.0 Inspection summary

An unannounced inspection took place on 10 December 2021 from 9.15am to 5.40pm 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 on 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 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 operations manager and the manager at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with 10 patients and six staff. Patients spoke positively on the care that they received and with their interactions with staff describing staff as 'brilliant' and 'lovely'. Patients also complimented the food and activity provision in the home. Staff were confident that they worked well together and enjoyed working in the home and interacting with the patients.

There were no questionnaire responses 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 11 February 2021		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for Improvement 1 **Ref:** Regulation 14 (2) (a) (c) **Stated:** Second time	The registered persons must ensure that all chemicals are securely stored in keeping with COSHH legislation to ensure that patients are protected at all times from hazards to their health.	**Met**
	Action taken as confirmed during the inspection: Chemicals were not found to be accessible to patients in any area of the home.	
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref**: Standard 11 **Stated:** First time	The registered person shall review the provision of activities in the home to ensure that all patients, who wish to engage, are included in regular meaningful activity.	**Met**
	Action taken as confirmed during the inspection: Discussion with patients and the activities therapist and a review of activity records evidenced that this area for improvement has now been met.	

Area for improvement 2 **Ref**: Standard 46 Criteria (2) **Stated:** First time	The registered person shall ensure that training provided on infection prevention and control and the use of personal protective equipment is embedded into practice.	**Met**
	Action taken as confirmed during the inspection: Observation of staffs' practices on infection prevention and control measures evidenced that this area for improvement has now been met.	
Area for improvement 3 **Ref**: Standard 47 **Stated:** First time	The registered person shall that equipment is only used for the purpose it was designed for. This is in reference to the use of a mattress as a fall-out bedside mat.	**Met**
	Action taken as confirmed during the inspection: The appropriate fall-out bedside mattresses were observed in use in the home.	

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. Three staff were of the opinion that the induction period should be longer for some staff, especially those who had not worked in the care sector before. Staffs' opinion were shared with the manager for their review and action as appropriate. 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 infection prevention and control (IPC), patient moving and handling and fire safety. A system was in place to ensure that staff completed their training. 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 consulted agreed that patients' needs were met with the number and skill mix of staff on duty, although, staff also confirmed that staffing levels can be affected at times by short term sick leave. Patients spoke highly on the care that they received.

Staff said there was good teamwork in the home and felt that they communicated well with each other. Effective communication was demonstrated in the home through daily staff handovers,

staff communication book, electronic group messaging, noticeboards, use of the diary and regular staff meetings. Staff confirmed that they understood their own roles in the home and the roles of others.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis and the designation in which they worked. The duty rota identified the nurse in charge of the home when the manager was not on duty. Any nurse designated to take charge of the home first completed a 'nurse in charge competency and capability assessment' to prepare them for the role.

Patients confirmed that they would have no issues on raising any concerns that they may have to staff. It was observed during the inspection 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. 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.

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. This was good practice. Staff were observed to be prompt in recognising patients' needs and any early signs of distress, especially in those patients who had difficulty in making their wishes known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

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. Patients' care records were held confidentially.

Where a patient was at risk of falling, a falls care plan was in place to direct staff in how to manage this area of care. Falls in the home were monitored monthly to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to prevent further falls from occurring. A review of accident records confirmed that the appropriate falls risk assessments and care plans had been updated following an accident in the home. Records also indicated that the appropriate persons had been notified of the fall and the patient had been monitored appropriately.

Patients who were less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly. Records of position changes had been recorded well and included checks on the patients' skin condition at the time of repositioning. Risk assessments had been completed to determine if patients were at risk of skin breakdown. Where a risk was identified, a care plan was in place to guide staff in the management of the risk.

At times some patients may be required to use equipment that can be considered to be restrictive. For example, alarm mats and/or bed rails. Discussion with the manager and a review of records evidenced that the proper procedures had been followed when a restrictive practice had been implemented. In addition, care plans were also in place to protect the human rights of the patients taking into account access and egress from the home.

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. Records of patients' intake and outputs were recorded where this was required. Nutritional risk assessments were carried out monthly to monitor for weight loss and weight gain using the Malnutrition Universal Screening Tool (MUST).

Patients could avail from a choice of meal at lunch and evening mealtimes. A system was in place to ensure that each patient's nutritional requirements had been communicated to all relevant staff. The dining room was well supervised by staff who were wearing the appropriate PPE and took the opportunity for hand hygiene at the appropriate times. A range of drinks were served with the meal. Signage was on display as a quick reference guide to identify allergens in baked foods. Patients spoke positively and were complimentary in relation to the food provision in the home.

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 detected in the home.

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. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices.

Systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated in the regional testing arrangements for patients and staff. Environmental infection prevention and control audits had been conducted monthly. There was evidence of oversight from senior management of the completed auditing records.

All visitors to the home had a temperature check and symptom checks when they arrived at the home. They were also required to wear personal protective equipment (PPE) and wash their hands on entry. Visits were by appointment only.

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.

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, patients could have a lie in or stay up late to watch TV. Patients confirmed that they could remain in their bedroom or go to a communal room when they requested. Patients, who could, could choose what they wore and what they preferred to eat.

An activities coordinator oversaw the activity provision in the home. A programme of activities was displayed and took into account group activities and one to one activities for those patients who could not engage in, or did not wish to engage in, group activity. Activities included arts and crafts, games, exercises, spelling, puzzles, pampering, aqua painting, music, prayers, hymns, companionship and bingo. Records were maintained daily of all activity provision in the home. In addition, the activity coordinator maintained a list of all patients in the home and was able to demonstrate when each patient had participated in or was offered participation in activities. This ensured that all patients who wished to engage in activities were offered the opportunity to. A monthly newsletter entitled 'The Daily Sparkle' was available for staff, patients and relatives to read and evidenced some of the activity provision in the home. Patients' birthdays were celebrated and plans were in place to celebrate Christmas. Patients spoke fondly on the provision of activities in the home.

There was evidence of regular meetings with patients and relatives. Topics discussed included COVID-19 updates, activity provision, food provision and menu, use of funding, laundry, housekeeping, visiting arrangements and any other business the patients wished to discuss. Minutes of the meetings were maintained including attendees, topics discussed and decisions made.

Visiting arrangements were in place in line with the Department of Health guidelines. An additional staff member had been employed to facilitate visiting. As well as indoor visiting, virtual and window visits were also continued. There were nine care partner arrangements in place in the home. Care partner agreement forms had been completed for each care partner to identify when, where and what care could be provided. Both the visiting and care partner arrangements were in place with positive physical and mental wellbeing benefits to the patients.

The patients' named nurse and key worker were identified, for ease of reference, on a notice on the patients' wardrobe doors in their bedrooms.

5.2.5 Management and Governance Arrangements

Since the last inspection there had been a change in the management arrangements. Mrs Ciara Cochrane had commenced the role of acting manager on 4 December 2021 while the home recruited for a permanent manager. Discussion with the manager and staff confirmed that there were good working relationships between staff and the management team in the home.

Staff were aware of who the person in charge of the home was in the manager's absence. Staff confirmed that the management team were approachable and would listen to them when they brought any concerns to their attention.

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, infection control and staff training. 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 their relatives were provided with written information on how to raise a concern or complaint about care or any service they received in the home. A complaints book was maintained. Complaints' records included the detail of the complaint and the actions taken in response to the complaint. A monthly analysis of complaints was completed in the home. A compliments book had also been maintained. All learning from complaints and any compliments received had been shared with staff.

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; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. Completed reports were available for review by patients, their representatives, the Trust and RQIA.

Review of staff training records confirmed that all staff completed adult safeguarding training. Staff told us they were confident about reporting any concerns about patients' safety. Staff were aware of who to report their concerns to and who to escalate their concern to if they felt that this was required.

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 Sharon Loane, Operations Director and Ciara Cochrane, Acting Manager, as part of the inspection process and can be found in the main body of the report.

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