Unannounced Care Inspection Report
23 October 2017

Sanville

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

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

This is a registered nursing home which is registered to provide nursing care and residential care for up to 40 persons.

3.0 Service details

Organisation/Registered Provider: Sanville **Responsible Individual:** Mr Brendan Gervin Mrs Alice Mc Aleer	**Registered Manager:** Miss Claire Reid
Person in charge at the time of inspection: Miss Claire Reid	**Date manager registered:** 7 July 2017
Categories of care: Nursing Home (NH) I – Old age not falling within any other category. PH – Physical disability other than sensory impairment. DE – Dementia. LD – Learning disability. LD (E) – Learning disability – over 65 years. MP – Mental disorder excluding learning disability or dementia. MP (E) - Mental disorder excluding learning disability or dementia – over 65 years. Residential Care (RC) I – Old age not falling within any other category. MP – Mental disorder excluding learning disability or dementia.	**Number of registered places:** 40 comprising: 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 persons only and category RC-MP for 1 identified person only. The home is also approved to provide care on a day basis for 1 person.

4.0 Inspection summary

An unannounced inspection took place on 23 October 2017 from 10.30 to 16.15 hours.

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 Care Standards for Nursing Homes 2015.

The term ‘patients’ is used to describe those living in the home which provides both nursing and residential care.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to the management of staffing, adult safeguarding and ensuring the home’s environment was safe.

Care records were well maintained and contained good details of patients' individual needs and preferences. There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, activities and the caring and compassionate manner in which staff delivered care.

There were no areas requiring improvement identified during this inspection.

Patients said they were happy with the care provided and enjoyed living in the home. Patients commented positively about the staff, management and the home owners. Those who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 Inspection outcome

	Regulations	Standards
Total number of areas for improvement	0	0

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Claire Reid, Registered 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.

4.2 Action/enforcement taken following the most recent inspection dated 5 May 2017

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 5 May 2017. There were no further actions required to be taken following the most recent inspection.

5.0 How we inspect

Prior to the inspection a range of information relevant to the service was reviewed. This included the following records:

- notifiable events since the previous care inspection
- written and verbal communication received since the previous care inspection which includes information in respect of serious adverse incidents (SAI's), potential adult safeguarding issues and whistleblowing.
- the returned QIP from the previous care inspection
- the previous care inspection report
- pre-assessment inspection audit

During the inspection the inspector met with 16 patients, eight staff, and one patient's visitor. Questionnaires were also left in the home to obtain feedback from patients, patients' representatives and staff not on duty during the inspection. Ten questionnaires for staff and relatives and eight for patients were left for distribution.

A poster informing visitors to the home that an inspection was being conducted was displayed.

The following records were examined during the inspection:

- staffing arrangements
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one staff recruitment and induction file
- four patient care records
- two patient care charts including food and fluid intake charts and reposition charts
- staff supervision and appraisal planners
- a selection of governance audits
- patient register
- complaints record
- compliments received
- RQIA registration certificate
- certificate of public liability
- monthly quality monitoring reports undertaken in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005

The findings of the inspection were provided to the registered manager at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 5 May 2017

The most recent inspection of the home was an unannounced medicines management inspection. No areas for improvement were identified.

6.2 Review of areas for improvement from the last care inspection dated 7 February 2017

There were no areas for improvement identified as a result of the last care inspection.

6.3 Inspection findings

6.4 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

The registered 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 rota for week commencing 23 October 2017 evidenced that the planned staffing levels were adhered to. Discussion with patients and staff evidenced that there were no concerns regarding staffing levels. Although some staff spoken with indicated that on occasions they felt staffing levels in the early evening were not adequate due to the level of supervision required for the dayrooms.

We also sought staff opinion on staffing via questionnaires; two questionnaires were returned by staff. The following question was included: Are there sufficient staff to meet the needs of the patients? One respondent answered "No" to this question and included the following written comment, "Not enough staff on in the evening."

This information was shared with the registered manager for consideration and actions as deemed appropriate. Observation of the delivery of care at the time of this inspection evidenced that patients' needs were met by the levels and skill mix of staff on duty.

A review of one recruitment record evidenced that it was maintained in accordance with Regulation 21, Schedule 2 of The Nursing Homes Regulations (Northern Ireland) 2005. Records confirmed that enhanced Access NI checks were sought, received and reviewed prior to staff commencing work.

The arrangements in place to confirm and monitor the registration status of registered nurses with the NMC and care staff registration with the NISCC were discussed with the registered manager. A review of the records of NMC registration evidenced that all of the nurses on the duty rota for the week of the inspection were included in the NMC check. The record of the checks of care staff registration included the expiry date of their registration with NISCC.

The registered manager confirmed that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. A review of induction programmes evidenced that these were completed within a meaningful timeframe.

We discussed the provision of mandatory training with staff and reviewed the training records for 2016/2017. Training records evidenced good compliance. The registered manager confirmed that they had systems in place to facilitate compliance monitoring.

Staff clearly demonstrated the knowledge, skill and experience necessary to fulfil their role, function and responsibility.

The registered manager and staff spoken with clearly demonstrated knowledge of their specific roles and responsibilities in relation to adult safeguarding and their obligation to report concerns. Discussion with the registered manager confirmed that there were arrangements in place to embed the new regional operational safeguarding policy and procedures into practice. A safeguarding champion had been identified.

A review of documentation confirmed that any potential safeguarding concern was managed appropriately in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately. Where any shortcomings were identified, safeguards were put in place.

Review of four patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that risk assessments informed the care planning process.

Review of management audits for falls confirmed that on a monthly basis the number, type, place and outcome of falls were analysed to identify patterns and trends. Action plans were in place to address any deficits identified. This information informed the responsible individual's monthly monitoring visit in accordance with Regulation 29 of The Nursing Homes Regulations (Northern Ireland) 2005.

Review sample of records pertaining to accidents, incidents and notifications forwarded to RQIA since the last care inspection confirmed that these were appropriately managed.

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, and the dining room and storage areas. The home was found to be warm, well decorated, fresh smelling and clean throughout. Patients and staff spoken with were complimentary in respect of the home's environment.

Fire exits and corridors were observed to be clear of clutter and obstruction. However, a discussion was held with the registered manager regarding the storage of some wheelchairs. Although these were not obstructing the fire exit the space in the corridor was somewhat reduced by the placement of same. The registered manager agreed to review this arrangement. Infection prevention and control measures were adhered to and equipment was appropriately stored.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, adult safeguarding, infection prevention and control, risk management and the home's environment.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care effective?

The right care, at the right time in the right place with the best outcome.

A review of four care records evidenced that a comprehensive assessment of need and a range of validated risk assessments were completed for each patient. Assessments were reviewed as required and at a minimum monthly. There was evidence that assessments informed the care planning process. Care records contained details of patients' individual needs and preferences.

We reviewed the management of catheter care for one patient. A care plan was in place which detailed the frequency for which the catheter was due to be changed and systems were in place to alert staff to when the next change was due. Care records evidenced that the catheter was changed in accordance with the prescribed frequency. There was also evidence that registered nurses had liaised with the continence specialist regarding the management of the patient's catheter. Records evidenced that the patient's intake and urinary output were recorded daily and totalled at the end of every 24 hour period.

We reviewed the management of wound care for one patient. The care plan included the grade and size of the wound and the prescribed dressing regime. An assessment of the wound was recorded after each dressing change for the majority of records reviewed. A review of wound care records evidenced that prescribed dressing regime was adhered to.

A number of patients had pressure relieving mattresses on their beds, to prevent skin breakdown. The correct mattress settings were indicated on the majority of mattress pumps, to ensure their effective use. However, some mattresses observed (two) were not set at the correct setting as per review of patient's weights. A discussion with staff demonstrated that they were knowledgeable regarding the use of the equipment and a system was in place to check these daily. The registered manager provided an explanation for same and agreed to review the current arrangements to assure the safe use of equipment. Post inspection, the registered manager confirmed by email of the actions taken in relation to same. This will be monitored at subsequent care inspections.

Care records for two patients were reviewed in relation to the management of weight loss and nutrition which evidenced that risk assessments and care plans had been reviewed and updated accordingly. Appropriate actions had been taken by nursing staff in response to identified needs and included referrals and/or liaisons with medical and other healthcare professionals. There was evidence in the care records that recommendations made by healthcare professionals had been adhered to accordingly. There was evidence of regular monitoring of patients weights in accordance with the level of risk identified and instructions outlined in the plan of care.

A sample review of food and fluid charts for the two identified patients evidenced that these were being maintained in accordance with best practice guidelines. The information included food and fluids refused. There was good evidence that food and fluids were offered at regular intervals. Charts reviewed evidenced that 24 hour fluid intake was calculated and totalled accurately and subsequently recorded in the patient's daily notes.

As discussed above a review sample of food and fluid intake charts was undertaken. A review sample of daily progress notes for the identified patients evidenced that registered nurses were recording the total fluid intake 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 two records. Entries recorded accurately reflected when food and fluid intake was satisfactory and/or inadequate. There was good evidence available to demonstrate that all registered nurses on duty over the 24 hour period had monitored and/or taken any action to address identified deficits. There was evidence that appropriate actions had been taken when intake was poor, for example, communication with the general practitioner (GP). This information was reflected in the patient's daily progress notes and evaluations of the care plans in place were updated to reflect any changes in the patient's progress and/or condition on a frequent basis.

There was evidence of oversight by management in regards to the monitoring of this area of care delivery. The registered manager had completed audits in regards to weight loss and dehydration. Action plans had been developed and there was evidence that the actions had been embedded. This is good practice.

Discussion with staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff confirmed that communication was good within the home and that they were provided with the relevant information in response to patient's daily needs and changing needs. Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that they enjoyed working in the home and with colleagues and if they had any concerns, they could raise these with the registered manager and /or the home owners who were in the home daily. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals.

The registered manager confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meetings were held for care staff and kitchen staff on 10 and 12 September 2017. A meeting for registered nurses was scheduled for 10 November 2017.

A record of patients including their name, religion, address, date of birth, marital status, religion, date of admission, date they left the home (where applicable) and details of where they were transferred to, details of death (where applicable) and the name of the public body responsible for arranging each patients admission was held in a patient register. This register provided an accurate overview of the patients residing in the home on the day of the inspection.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to record keeping, audits and reviews, communication between residents, staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

We arrived in the home at 10.15 hours. There was a calm atmosphere and staff were busy attending to the needs of the patients. Patients were observed either in their bedrooms as was their personal preference, walking around the home or seated in the lounges again in keeping with their personal preference. Staff interaction with patients was observed to be compassionate, caring and timely. Patients were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

There was evidence that patients were involved in decision making about their care. Patients were consulted with regarding meal choices and were offered a choice of meals, snacks and drinks throughout the day. Staff encouraged those patients who could express their preference to do so and demonstrated a detailed knowledge of patients' likes and dislikes for those patients who were unable to express their opinion.

All patients spoken with commented positively regarding the care they received and the caring and kind attitude of staff. Discussion with patients individually and with others in smaller groups, confirmed that they were content living in the home.

These are examples of some of the comments received:

"Just in recently – greatly received and welcomed and the food is first class."
"Very well looked after."
"Staff are second to none we are living in a hotel couldn't be better."

We spoke with one patient's visitor who commented positively with regard to the standard of care and atmosphere in the home.

Numerous compliments had been received and were displayed in the home in the form of thank you cards. The following is an extract from a letter received:

"I am aware that care is often demanding and exhausting and requires lots of physical and emotional energy. I have observed that the care given to residents is delivered really well-genuine-compassion-kindness and patience. I can now go to my bed and sleep in the knowledge that … now receives care which I am now unavailable to give."

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients and their representatives on the running of the home. A copy of the annual quality report for 2016/2017 was reviewed and available for all relevant stakeholders to access. The registered manager advised that questionnaires had recently been issued to patients and their representatives for the annual quality report for 2017/2018.

We reviewed the provision of activities and were informed by patients that they looked forward to the different events that were planned throughout the day. We spoke with the person employed to deliver activities who continues to be enthusiastic regarding their role in the home. They confirmed that there was wide a variety of activities planned each week which included community events and arrangements were in place to meet patients' religious wishes.

At the time of the inspection some patients spoke with the inspector regarding the activity that they were participating in, which was about the “tree of life” in Sanville. Both patients expressed their enjoyment and provided an analogy that represented the activity, “Life is colourful and beautiful.”

We issued questionnaires to patients (eight), relatives (ten) and staff (ten) who were not consulted with during the inspection. Two staff, eight patients and seven relatives returned their questionnaires within the timescale for inclusion in this report. All respondents indicated that they were either “very satisfied or satisfied” that safe, effective and compassionate care was being delivered and that the service was well-led. A written comment received in regards to staffing has been included in section 6.4 of the report. No other written comments were received.

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

6.7 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA and the home’s certificate of public liability insurance were appropriately displayed in the foyer of the home.

Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered. The Statement of Purpose and Patient Guide were available in the home.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion patients were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

Discussion with the registered manager and review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed in accordance with Regulation 24 of The Nursing Homes Regulations (Northern Ireland) 2005 and the Care Standards for Nursing Homes 2015. A copy of the complaints procedure was displayed in various locations within in the home.

A review of records evidenced that robust governance arrangements were in place. Areas audited included but were not limited to; trend analysis of accidents and incidents, wound care, patients' weights, hydration audits, complaints, and environmental audits. The records of audit evidenced that any identified areas for improvement had been reviewed to check compliance and drive improvement.

A review of notifications of incidents submitted to RQIA since the last care inspection confirmed that these were managed appropriately.

Review of records evidenced that unannounced quality monitoring visits were completed on a monthly basis by the responsible person. An action plan was included within the report to address any areas for improvement. The action plan was reviewed at the next visit. A copy of the quality monitoring reports was available in the home.

There were systems and processes in place to ensure that urgent communications, safety alerts and notices were reviewed and where appropriate, made available to key staff in a timely manner.

Discussions with the staff confirmed that there were good working relationships and that management were responsive to any suggestions or concerns raised. Staff consulted with described management and the owners of the home in very positive terms and felt confident that they would respond positively to any concerns and/or suggestions raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of complaints and incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

The Regulation and Quality Improvement Authority

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