The Regulation and Quality Improvement Authority

Inspection Report

28 July 2022

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 - 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:** 34
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 28 July 2022 from 9.40am to 5.30pm by a care inspector.

The inspection sought 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 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 management team at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we consulted with 13 patients, three relatives and eight staff. Patients spoke positively on the care that they received and with their interactions with staff describing staff as 'very kind' and 'lovely'. Patients also complimented the food 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?

The last inspection to Sanville was undertaken on 10 December 2021 by a care inspector; no areas for improvement were identified.

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. Recently employed staff consulted complimented the induction process. 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.

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 that staff completed their training and evidenced that the majority of staff had achieved compliance with this. Staff confirmed that they were further supported through staff supervisions and appraisals. There was evidence of recent supervisions conducted with staff in relation to patient moving and handling, uniform policy, personal care, hand hygiene and in the use of thickening agents. In addition, registered nurses had completed supervisions on medicines management, patients' distressed reactions and with taking charge of the home in the absence of the manager.

The manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met. Staff confirmed that they were busy in the home but added that patients' needs were met with the number and skill mix of staff on duty. Staff said there was good teamwork in the home. The staff consulted confirmed that at times when they were short

staffed, due to unplanned short term sick leave, for example, that this can be challenging but also confirmed that the team 'pull together well' on these occasions.

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 and those staff who were on induction. The duty rota identified the nurse in charge when the manager was not on duty.

Patients spoke highly on the care that they received and confirmed that staff attended to them when they needed them and that they would have no issues on raising any concerns that they may have to staff. 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. 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 provided care in a caring and compassionate manner. A relative commented, "The staff here are very friendly, welcoming and exceptionally kind. There is a good team spirit in the home." Patients told us that they 'were happy' living in the home. One said, "Staff are excellent. I am very happy here and intend staying here and making this my home." Another commented, "I am happy here. It is a good place and they keep it very clean."

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.

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. 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.

When a patient had a wound, an initial wound assessment was completed and a wound care plan developed to guide staff in the treatment of the wound. Wound evaluations were recorded at the time of wound dressing to monitor the progress of the wound treatment. Body maps were in place to identify the specific location of the wound and a photograph of the wound was within the patient's care records as a visual reference. Wound care had been managed well in the home.

An accident book was completed by staff to record any accidents or incidents which occurred in the home. Following any fall in the home a post fall performa was conducted by the manager to ensure that the appropriate actions had been taken following the fall; the

appropriate persons notified and the appropriate records updated. This was good practice. There was evidence that recent supervisions had been conducted with registered nurses reinforcing the management of falls in 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. These records also included when mouth care had been provided to patients. Staff paid particular attention to daily fluid intake, especially on warm days, to ensure patients did not become dehydrated. 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 within the dining room during lunch. Tables had been set before the meal with flowers, cutlery and condiments. The mealtime was well supervised. 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 and the menu offered a choice of 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. One patient told us, "The food is really good here and we can get a cup of tea whenever we want."

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. Appropriate doors had been locked to prevent patients coming into contact with avoidable hazards. There was evidence of ongoing improvement works in progress with new flooring replaced in various identified areas in the home. There was signage around the home advising of the improvement works.

Patients could enjoy sitting outside in the good weather. Seating areas were available within a well maintained garden.

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. All visitors to the home were required to

wear face coverings. Visits were by appointment only. Environmental infection prevention and control audits had been conducted monthly.

Each patient who required to have a hoist sling to aid in moving and handling now has their own sling identified for their own personal use only. A system was in place for staff to identify which sling was to be used for each patient.

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. In addition, supply and availability of PPE and hand hygiene gels was also audited to ensure adequate provision.

5.2.4 Quality of Life for Patients

Patients confirmed that they were offered choice and assistance on 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. One patient told us, “I love it here. Staff are great. I can pick my own food and clothing to wear. I choose when to get up. I feel that I could raise any issues with staff but I have no concerns”. A relative told us, “The home is fabulous; great care. xxx is always immaculate. I can take them out for lunch when I want. The home staff always keep us up to date with xxx care.” Another relative commented, “We as a family are very happy with the care in the home. It is so clean and nothing is ever a bother to staff. Xxx has made new friends here and settled in very well. We are always made to feel welcome anytime we come.”

The home were in the process of recruiting for a new activity therapist. In the interim, additional staff had been rostered to work to provide activities to patients. There was a good supply of resources available for activity provision in the home. A record was maintained of all completed activities in the home.

Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients. There were 12 care partner arrangements in place and visiting was conducted in line with Department of Health guidelines.

5.2.5 Management and Governance Arrangements

Since the last inspection there had been no change in the management arrangements. Mrs Ciara Cochrane assumed the manager’s position on 6 December 2021and plans were in place for Ciara to register as manager with RQIA. Discussion with the manager and staff confirmed that there were good working relationships between staff and the home’s management team.

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, care practices or the environment.

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 care records, restrictive practice,

staff training and maintenance of staffs' registrations. 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.

A complaint's book was maintained to detail the nature of any complaints and the corresponding actions made in response to any complaints. Any complaints were shared with the patients' care managers.

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 were required to complete adult safeguarding training on an annual basis. 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.

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 Ciara Cochrane, Manager and the senior management team as part of the inspection process and can be found in the main body of the report.

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