

Inspection Report

Name of Service: Springlawn Nursing Home

Provider: Springlawn House Limited

Date of Inspection: 19 November 2024

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

1.0 Service information

Organisation/Registered Provider:	Springlawn House Limited
Responsible Individual:	Mrs Linda Florence Beckett
Registered Manager:	Mrs Sharon Margaret Colhoun – not registered.
Service Profile:	
<p>This home is a registered nursing home which provides nursing care for up to 40 patients in frail elderly over 65 years of age; up to four patients with physical disability under 65 years of age and one patient with mental health under 65 years of age. There is also one named resident receiving residential care in frail elderly over 65 years of age.</p> <p>The home is a two storey building. Patient bedrooms and living areas are located over two floors with access to communal lounges, dining areas and a garden.</p>	

2.0 Inspection summary

An unannounced inspection took place on 19 November 2024, from 9.15 am to 5.30 pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection found that care was delivered to patients in a compassionate manner and that the home was well led. It was evident that staff promoted the well-being of patients and that staff were knowledgeable and trained to deliver safe and effective care. Details and examples of the inspection findings can be found in the main body of the report.

Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Refer to Section 3.2 for more details.

It was positive to note that eleven out of the thirteen areas for improvement were assessed as having been addressed by the provider during this inspection. Two areas for improvement have

been stated for a second time. Full details, including new areas for improvement identified, can be found in the main body of this report and in the quality improvement plan (QIP) in Section 4.

3.0 The inspection

3.1 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how the home was performing against the regulations and standards, at the time of our inspection, highlighting both good practice and any areas for improvement. It is the responsibility of the 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 patient's, relatives, staff or the commissioning trust.

Throughout the inspection process inspectors seek the views of those living, working and visiting the home; and review/examine a sample of records to evidence how the home is performing in relation to the regulations and standards.

Through actively listening to a broad range of service users, RQIA aims to ensure that the lived experience is reflected in our inspection reports and quality improvement plans.

3.2 What people told us about the service

Patients spoke positively about their experience of life in the home; they said they felt well looked after by the staff who were helpful and friendly. Patients' comments included: "I am getting well looked after here", "The staff are wonderful", "It couldn't be better" and "I feel really safe here".

Patients told us that they were able to choose how they spent their day; that they could remain in their bedroom or go to a communal room when they requested. One patient said: "This is the best nursing home" and a further patient said: "The staff are all very good here. I couldn't praise them enough. They always attend to my needs quickly".

3.3 Inspection findings

3.3.1 Staffing Arrangements

Safe staffing begins at the point of recruitment and continues through to staff induction, regular staff training and ensuring that the number and skill of staff on duty each day meets the needs of patients. There was evidence of robust systems in place to manage staffing.

Patients said that there was enough staff on duty to help them. Staff said there was good team work and that they felt well supported in their role and that they were satisfied with the staffing levels. It was observed that staff responded to requests for assistance promptly, in a caring and compassionate manner.

Observation of the delivery of care evidenced that patients' needs were met by the number and skills of the staff on duty.

3.3.2 Quality of Life and Care Delivery

Staff interactions with patients were observed to be polite, friendly, warm and supportive and the atmosphere was relaxed, pleasant and friendly. Staff were knowledgeable of individual patients' needs, their daily routine, wishes and preferences.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering and discussing patients' care in a confidential manner.

Staff were also observed offering patient choice in how and where they spent their day or how they wanted to engage socially with others.

At times some patients may require the use of equipment that could be considered restrictive. It was established that safe systems were in place to safeguard patients and to manage this aspect of care.

Patients may require special attention to their skin care. These patients were assisted by staff to change their position regularly and care records accurately reflected the patients' assessed needs.

Examination of care records and discussion with the manager confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. The dining experience was an opportunity for patients to socialise, and the atmosphere was calm, relaxed and unhurried. There was a menu on display within the dining room offering a choice of two meals.

A mealtime co-ordinator was allocated to oversee the correct delivery of meals to patients. It was observed that patients were enjoying their meal and their dining experience. Whilst the main meal was covered on transport to patients within their bedroom, the soup and desserts were not. This was brought to the attention of staff who immediately had this addressed. The manager agreed to monitor this going forward.

Patients commented positively about the food provided within the home with comments such as: "The food is powerful", "Good portions and plenty of choices", "We get a very good choice of food", and "The food is very good".

The importance of engaging with patients was well understood by the manager and staff. An activity schedule was on display within the home offering a range of individual and group activities such as baking, bingo, crafts, bowls, games, quizzes and exercises.

The activity co-ordinator advised that patients recently attended a local country music event and provided examples of other events that took place in the home over previous months, such as; a summer garden party and a Halloween fancy dress party. Other events have been scheduled for the period leading up to Christmas.

The activity co-ordinators were very enthusiastic in their role and were observed positively engaging with patients and encouraging them to participate in activities. During the inspection chair exercises were provided in the morning and a quiz in the afternoon; patients appeared to enjoy the activities provided.

Some patients were engaged in their own activities such as; watching TV, resting or chatting to staff. Patients were seen to be content and settled in their surroundings and in their interactions with staff.

3.3.3 Management of Care Records

Patients' needs were assessed by a nurse 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.

Review of two patients care records evidenced that a number of risk assessments had not been completed within the required timeframe following admission to the home. Details were discussed with the manager and an area for improvement has been stated for a second time.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs and nursing staff recorded regular evaluations about the delivery of care. Some care plans required further information regarding patients spiritual care needs; details were discussed with the manager who agreed to have these updated. Following the inspection, written confirmation was received that relevant care records had been updated.

Wound care records for one patient evidenced that the recommended frequency for dressing renewal and the dressings applied to the wounds as stated within the wound care evaluation records, were not consistent with the care plans. An area for improvement has been stated for a second time.

3.3.4 Quality and Management of Patients' Environment

The home was clean, neat and tidy and patients' bedrooms were personalised with items important to the patient. There was evidence that refurbishment work had been completed within a lounge and a number of bedrooms since the last care inspection, however, a number of carpets within corridor areas were worn and floor coverings within identified bedrooms required replacing. The responsible individual discussed the homes refurbishment plans and that these floor coverings were on the homes agenda to be replaced; evidence of this was documented within an environmental action plan. Progress with this will be reviewed at a future inspection.

Whilst assurances were received that environmental issues were being addressed; staining to an identified bedroom carpet was unable to be removed and the management were asked to prioritise the replacement of this floor covering. An area for improvement was identified.

There was evidence that systems and processes were in place to manage infection prevention and control which included policies and procedures and regular monitoring of the environment and staff practice to ensure compliance.

3.3.5 Quality of Management Systems

There has been a change in the management of the home since the last inspection. Mrs Sharon Margaret Colhoun is now the Acting Manager from the 4 November 2024, to cover a period of planned leave for Mrs Clara Houston who has been the Manager in this home since 19 August 2021.

Staff commented positively about the management team and described them as supportive, approachable and able to provide guidance.

Review of a sample of records evidenced that a robust system for reviewing the quality of care, other services and staff practices was in place. There was evidence that the management team responded to any concerns, raised with them or by their processes, and took measures to improve practice, the environment and/or the quality of services provided by the home.

4.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with the Standards.

	Regulations	Standards
Total number of Areas for Improvement	0	3*

* The total number of areas for improvement includes two standards that have been stated for a second time.

Areas for improvement and details of the Quality Improvement Plan were discussed with the management team, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan	
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 Ref: Standard 23 Stated: Second time To be completed by: 19 November 2024	<p>The registered person shall ensure that wound care plans contain the recommended frequency for dressing renewal and wound care evaluation records are reflective of the dressings within the care plan.</p> <p>Ref: 2.0 and 3.3.3</p> <hr/> <p>Response by registered person detailing the actions taken: New wound care folder ongoing, staff nurses spoken to following inspection and aware of second time highlighted. Wound care will be focused on all audits</p>
Area for improvement 2 Ref: Standard 4.1 Stated: Second time To be completed by: 19 November 2024	<p>The registered person shall ensure that for any patient being admitted to the home, relevant risk assessments are completed within the required timeframe.</p> <p>Ref: 2.0 and 3.3.3</p> <hr/> <p>Response by registered person detailing the actions taken: New documentation now in use with appropriate timescale required for admissions timeframe</p>
Area for improvement 3 Ref: Standard 44.1 Stated: First time To be completed by: 14 January 2025	<p>The registered person shall ensure that the carpet in the identified bedroom is replaced.</p> <p>Ref: 3.3.4</p> <hr/> <p>Response by registered person detailing the actions taken: Carpet will be replaced within the next 6 weeks sourcing floor</p>

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