The Regulation and Quality Improvement Authority

Inspection Report

Name of Service: Sandringham

Provider: Ann's Care Homes

Date of Inspection: 03 June 2025

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:	Ann's Care Homes
Responsible Individual:	Mrs Charmaine Hamilton
Registered Manager:	Mrs Tracey Palmer
Service Profile – This home is a registered nursing home which provides nursing care for up to 63 patients. The home is spread over two wings; the East Wing where patients are cared for who are living with dementia and over 65 years; and the West Wing where patients are provided general nursing care and are over 65 years. There are communal living and dining areas in both Wings and access to a private garden.	

2.0 Inspection summary

An unannounced inspection took place on 3 June 2025, from 9.15 am to 5.30pm by a care inspector.

The inspection was undertaken to evidence how the home is performing in relation to the regulations and standards; to assess progress with the areas for improvement identified, by RQIA, during the last inspection; and to determine if the home is delivering safe, effective and compassionate care and if the service is well led.

The inspection found that safe, effective and compassionate care was delivered to patients and that the home was well led. Details and examples of the inspection findings can be found in the main body of the report.

It was evident that staff promoted the dignity and well-being of patients and that staff were knowledgeable and well trained to deliver safe and effective care.
Patients said that living in the home was a good experience. Patients unable to voice their opinions were observed to be well presented, relaxed and comfortable in their surroundings and in their interactions with staff.

As a result of this inspection all of the previous areas for improvement were assessed as having been addressed by the provider and no new areas for improvement were identified. Details can be found in the main body of this report.

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. Inspectors will also observe care delivery and may conduct a formal structured observation during the inspection.

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 told us, "it's lovely here" and "the people are really nice", "the staff are respectful and kind and gentle" and "I have no issues, I am happy enough here". Others said, "the food is good here", and "staff support me to go for walks", and "the activities are good", advising that planned activities were of interest to them and various others and that there was a good variety.

Discussion with patients confirmed that they were able to choose how they spent their day; some liked to spend the morning in the lounge and the rest of the afternoon in their bedroom watching TV, others liked to spend the morning in their room and socialise with others in the afternoon.

Patients told us that they were encouraged to participate in regular residents' meetings which provided an opportunity for them to comment on aspects of the running of the home. For example, planning activities.

Relatives advised that communication was very good between the home staff and family. They spoke of feeling confident that their loved one was being well cared for and that staff knew their loved one well enough to encourage them in a way that works. Relatives and patients told us that staff facilitated independence in tasks, supporting patients to feel confident.

Relative questionnaires returned confirmed that patients and relatives were satisfied with the delivery of care.

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.

A small sample of patients said that there were not always enough staff on duty to help them. This was discussed with the manager for her review. Staff said that they were satisfied with the staffing levels, there was good team work and that they felt well supported in their role. There was enough staff to provide activities. Staff knew what they were doing and patients told us that staff knew them well and knew how best to help them. It was noted that there was enough staff in the home to respond to the needs of the patients in a timely way; and to provide patients with a choice on how they wished to spend their day.

There was a robust system in place to identify the person in charge of the home in the absence of the manager and staff knew who to escalate concerns to.

3.3.2 Quality of Life and Care Delivery

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

Staff were observed to be prompt in recognising patients' needs and any early signs of distress or illness, including those patients who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with patients; they were respectful, understanding and sensitive to patients' needs.

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. Patients were also asked both at lunch time, and when in communal areas where they wished to sit in the room.

At times some patients may require the use of equipment that could be considered restrictive or they may live in a unit that is secure to keep them safe. 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.

Where a patient was at risk of falling, measures to reduce this risk were put in place. For example, alarm mats were utilised where a person was a high risk of falls, but wished to have the option of getting up on their own. Patients were also encouraged to wear appropriate footwear.

Examination of care records and discussion with staff confirmed that the risk of falling and falls were well managed and referrals were made to other healthcare professionals as needed. For example, patients were referred to the Trust's Falls Prevention Service, their GP, or to Physiotherapy. One identified patient's records were discussed with the manager for her review and action as decision making for the incident had not been clearly documented.

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 may include simple encouragement through to full assistance from staff and their diet modified.

The dining experience was an opportunity for patients to socialise, choosing who they sat beside. It was observed that patients were enjoying their meal and their dining experience. Staff in the East Wing confirmed that staff attended 'safety pauses' prior to mealtimes to ensure good communication across the team about changes in patients' needs. The was followed by a staff member being identified as 'mealtime coordinator' who further directed the lunchtime to ensure patients received the appropriate meal. This was less clear in the West wing and was discussed with the manager for her review.

Staff demonstrated effective communication to ensure patient's preferences were met for example, which drinks were requested at lunch. Staff also demonstrated caring with dignity; where a person required assistance with their meal, the staff member confirmed which foods the patient wished to eat together and offering if they wished to have a break. This enhanced the patients experience of their lunch and facilitated choice.

The importance of engaging with patients was well understood by the manager and staff. The home hosted a religious service as their morning activity. Staff knew and understood patients' preferences and wishes and helped those who wished to participate. There were others who did not wish to engage in this who preferred to remain in their bedroom with their chosen activity such as reading, listening to music or watching TV, or enjoyed some time socialising in another communal area in the home.

The home has dedicated activity therapists who work together and with the patients to ensure that the planned activities meet their ability and interest. The anticipated activities of the week are shared in each patients' room for their information. Some of these activities included Reflexology, Trip to Shops, and visits from the local Parish, and table-top games.

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.

Care records were person centred, well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Nursing staff recorded regular evaluations about the delivery of care. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

A small sample of Care Plans were reviewed of patients who were subject to Deprivation of Liberty Safeguards. These did not have information to direct the required care clearly identifiable. When brought to the attention of the manager, this was addressed and will be reviewed at a future inspection.

3.3.4 Quality and Management of Patients' Environment Control

The home was clean, tidy and well maintained. For example, patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, including photographs of patients engaged in various activities and parties. The home was suitably furnished, warm and comfortable.

The home was free from clutter and there was a display of 'Thank You' cards from relatives on a communal wall.

The manager had a system in place to ensure that air flow mattress, used to support patients in the prevention of pressure damage, were at the correct setting for each patient. These checks were completed twice daily. However, this system was not robust as there was small sample of mattress where the mattress did not reflect the patient's current weight. The was brought to the attention of the staff who addressed this immediately and this will be reviewed at a future inspection.

3.3.5 Quality of Management Systems

There has been no change in the management of the home since the last inspection. Ms Tracey Palmer has been the manager in this home since the last inspection.

Patients and staff commented positively about the manager and the management team, describing them as supportive, approachable and able to provide guidance.

The home has been involved with My Home Life, a programme for care homes to develop how they can achieve Best Practice and building relationships to improve the experience of the people live in the care homes or use their services.

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 manager 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.

It was clear from the records examined that the Management Team had processes in place to monitor the quality of care and other services provided to patients.

Patients and their relatives said that they knew who to approach if they had a complaint and they had confidence that any complaint would be managed well. Patients advised that they felt communication with staff was effective and allowed them to discuss issues and have them addressed promptly.

4.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Tracey Palmer, Manager as part of the inspection process and can be found in the main body of the report.

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