

# Inspection Report

**Name of Service:** Sunnyside Retreat Care Home

**Provider:** Ann's Care Homes

**Date of Inspection:** 31 October 2024

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

## 1.0 Service information

<b>Organisation/Registered Provider:</b>	Ann's Care Homes
<b>Responsible Individual:</b>	Mrs Charmaine Hamilton
<b>Registered Manager:</b>	Miss Edel Treanor
<b>Service Profile:</b> This home is a registered nursing home for up to 19 patients requiring physical disability and mental health care. Patient accommodation offers a variety of accommodation single, ensuite bedrooms and two larger suites comprising of an ensuite shower room with adjoining bedroom and kitchen space. Patients have access to communal lounges, a dining room and outdoor spaces.	

## 2.0 Inspection summary

An unannounced inspection took place on 31 October 2024, from 10:30 am to 4:30 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 established 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 relaxed and comfortable in their surroundings and in their interactions with staff.

This inspection resulted in no areas for improvement being identified.

## **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 told us they were happy with the care and services provided. Comments made included "the food is lovely here" and "I really enjoy the shopping trips".

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 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 and menu choices.

Staff spoke in positive terms about the provision of care, their roles and duties, training and managerial support with comments such as "I really enjoy working here", "there is really good teamwork".

Following the inspection, no responses were received regarding patient/relative questionnaires and no staff questionnaires were received within the timescale specified.

### 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.

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

Staff told us that the patients' needs and wishes were important to them. Staff responded to requests for assistance promptly in a caring and compassionate manner. It was clear through observation of the interactions between the patients and staff that the staff knew the patients well.

#### 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 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. 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 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.

Examination of care records and discussion with staff confirmed that the risk of falling and falls were well managed.

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 and the atmosphere was calm, relaxed and unhurried. It was observed that patients were enjoying their meal and their dining experience. It was clear that staff had made an effort to ensure patients were comfortable, had a pleasant experience and had a meal that they enjoyed.

The importance of engaging with patients was well understood by the manager and staff.

Life story work with patients and their families helped to increase staff knowledge of their patients' interests and enabled staff to engage in a more meaningful way with their patients throughout the day.

The weekly programme of social events was displayed on the noticeboard advising of future events. Patients' needs were met through a range of individual and group activities such as hand massage, card games, shopping trips, music therapy and pampering sessions.

Patients were well informed of the activities planned for the week and of their opportunity to be involved and looked forward to attending the planned events.

Patients said that they felt staff listened to them and would make an effort to sort out any concerns they might have.

Staff and patients spoke positively about recent events held in the home such as a Halloween party, BBQ and ice-cream van visit.

Arrangements were in place to meet patients' social, religious and spiritual needs within the home.

### **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.

### **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, suitably furnished, warm and comfortable.

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.

Review of records and observations confirmed that there were systems and processes 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.

### **3.3.4 Quality of Management Systems**

There has been no change in the management of the home since the last inspection. Miss Edel Treanor has been the manager in this home since 22 December 2022.

Patients and staff commented positively about the manager and described her 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 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**

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



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