Inspection Report

Name of Service: Edgewater Lodge

Provider: Electus Healthcare 1 Limited

Date of Inspection: 3 September 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:	Electus Healthcare 1 Limited
Responsible Individual:	Mr Ed Coyle
Registered Manager:	Mrs Karen Nicholson, not registered

Service Profile
Edgewater Lodge is a nursing home registered to provide nursing care for up to 58 patients. The home is divided into three units. Copeland Suite provides general nursing care; Orlock Suite and Lighthouse Suite provide care for people living with dementia.

A residential care home occupies the same building and the manager for this home is responsible for both services.

2.0 Inspection summary

An unannounced inspection took place on 3 September 2024, from 10.15am to 2.30pm. This was completed by two pharmacist inspectors and focused on medicines management within the home.

Review of medicines management found that robust arrangements were in place for the safe management of medicines. Medicines were stored securely. Medicine records and medicine related care records were generally well maintained. There were effective auditing processes in place to ensure that staff were trained and competent to manage medicines and patients were administered their medicines as prescribed. No new areas for improvement were identified.

RQIA would like to thank the staff for their assistance throughout the inspection.

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 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 information held by RQIA about this home was reviewed. This included areas for improvement identified at previous inspections, registration information, and any other written or verbal information received from patients, relatives, staff or the commissioning trust.

The inspection was completed by reviewing a sample of medicine related records, the storage arrangements for medicines, staff training and the auditing systems used to ensure the safe management of medicines, to evidence how the home is performing in relation to the regulations and standards. Discussions were held with staff and management about how they plan, deliver and monitor the management of medicines.

3.2 What people told us about the service and their quality of life

Throughout the inspection the RQIA inspector will seek to speak with patients, their relatives or visitors and staff to obtain their opinions on the quality of the care and support, their experiences of living, visiting or working in this home.

The inspector spoke with a range of staff and management to seek their views of working in the home.

Staff expressed satisfaction with how the home was managed. They also said that they had the appropriate training to look after patients and meet their needs. They said that the team communicated well and the management team were readily available to discuss any issues and concerns should they arise.

Feedback methods included a staff poster and paper questionnaires which were provided to the manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. At the time of issuing this report, no questionnaires had been received by RQIA.

3.3 Inspection findings

3.3.1 What arrangements are in place to ensure that medicines are appropriately prescribed, monitored and reviewed?

Patients in nursing homes should be registered with a general practitioner (GP) to ensure that they receive appropriate medical care when they need it. At times patients' needs may change and therefore their medicines should be regularly monitored and reviewed. This is usually done by a GP, a pharmacist or during a hospital admission.

Patients in the home were registered with a GP and medicines were dispensed by the community pharmacist.

Personal medication records were in place for each patient. These are records used to list all of the prescribed medicines, with details of how and when they should be administered. It is important that these records accurately reflect the most recent prescription to ensure that

medicines are administered as prescribed and because they may be used by other healthcare professionals, for example, at medication reviews or hospital appointments.

The personal medication records reviewed were mostly accurate and up to date. In line with best practice, a second member of staff had checked and signed the personal medication records when they were written and updated to confirm that they were accurate. One minor discrepancy was highlighted to nurses for immediate corrective action and on-going vigilance.

Copies of patients' prescriptions/hospital discharge letters were retained so that any entry on the personal medication record could be checked against the prescription. This is good practice.

All patients should have care records which detail their specific care needs and how the care is to be delivered. In relation to medicines these may include care plans for the management of distressed reactions, pain, modified diets etc.

Patients will sometimes get distressed and will occasionally require medicines to help them manage their distress. It is important that care records are in place to direct staff when it is appropriate to administer these medicines and that records are kept of when the medicine was given, the reason it was given and what the outcome was. If staff record the reason and outcome of giving the medicine, then they can identify common triggers which may cause the patient's distress and if the prescribed medicine is effective for the patient.

The management of medicines, prescribed on a 'when required' basis for distressed reactions, was reviewed. Directions for use were clearly recorded and care records directing the use of these medicines were in place for the majority of patients. One patient who used these medicines infrequently required a care plan to direct staff. The manager provided an assurance that this would be implemented immediately following the inspection. Staff knew how to recognise a change in a patient's behaviour and were aware that this change may be associated with pain and other factors. Records of administration included the reason for and outcome of each administration.

The management of pain was discussed. Staff advised that they were familiar with how each patient expressed their pain and that pain relief was administered when required. Care records were in place and reviewed regularly. One care plan required an update to reflect the most recent prescribed medicines, this was highlighted to nurses for immediate action.

Some patients may need their diet modified to ensure that they receive adequate nutrition. This may include thickening fluids to aid swallowing and food supplements in addition to meals. Care records detailing how the patient should be supported with their food and fluid intake should be in place to direct staff. All staff should have the necessary training to ensure that they can meet the needs of the patient.

The management of thickening agents was reviewed. Speech and language assessment reports and care records were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

Care records were in place when patients required insulin to manage their diabetes. There was sufficient detail to direct staff if the patient's blood sugar was outside of the recommended range.

The management of warfarin was reviewed. Warfarin is a high risk medicine and safe systems must be in place to ensure that patients are administered the correct dose and arrangements are in place for regular blood monitoring. Review of the administration records and audits completed at the inspection identified generally satisfactory arrangements were in place for the management of warfarin. However, some obsolete warfarin administration records had not been archived appropriately and remained in the medicines file. Prompt cancellation and archiving of records is necessary to ensure that nurses do not refer to obsolete directions in error and administer the wrong dose to the patient. Nurses actioned this immediately and it was agreed that this will continue to be monitored through the home's audit system.

Some patients cannot take food and medicines orally; it may be necessary to administer food and medicines via an enteral feeding tube. The management of medicines and nutrition via the enteral route was examined. An up to date regimen detailing the prescribed nutritional supplement and recommended fluid intake was in place. Records of administration of the nutritional supplement and water were maintained. Staff on duty advised that they had received training and felt confident to manage medicines and nutrition via the enteral route.

3.3.2 What arrangements are in place to ensure that medicines are supplied on time, stored safely and disposed of appropriately?

Medicine stock levels must be checked on a regular basis and new stock must be ordered on time. This ensures that the patient's medicines are available for administration as prescribed. It is important that they are stored safely and securely so that there is no unauthorised access and disposed of promptly to ensure that a discontinued medicine is not administered in error.

Records reviewed showed that medicines were available for administration when patients required them.

The medicine storage areas were observed to be securely locked to prevent any unauthorised access. They were tidy and organised so that medicines belonging to each patient could be easily located. Temperatures of medicine storage areas were monitored and recorded to ensure that medicines were stored appropriately. Satisfactory arrangements were in place for medicines requiring cold storage and the storage of controlled drugs.

Satisfactory arrangements were in place for the safe disposal of medicines.

3.3.3 What arrangements are in place to ensure that medicines are appropriately administered within the home?

It is important to have a clear record of which medicines have been administered to patients to ensure that they are receiving the correct prescribed treatment.

A sample of the medicines administration records was reviewed. All of the records were found to have been accurately completed. Records were filed once completed and were readily retrievable for audit/review.

Controlled drugs are medicines which are subject to strict legal controls and legislation. They commonly include strong pain killers. The receipt, administration and disposal of controlled drugs should be recorded in the controlled drug record book. There were satisfactory arrangements in place for the management of controlled drugs.

Occasionally, patients may require their medicines to be crushed or added to food/drink to assist administration. To ensure the safe administration of these medicines, this should only occur following a review with a pharmacist or GP and should be detailed in the patient's care records. Written consent and care records were in place when this practice occurred.

Management and staff audited medicine administration on a regular basis within the home. A range of audits were carried out. The date of opening was recorded on medicines so that they could be easily audited. This is good practice.

3.3.4 What arrangements are in place to ensure that medicines are safely managed during transfer of care?

People who use medicines may follow a pathway of care that can involve both health and social care services. It is important that medicines are not considered in isolation, but as an integral part of the pathway, and at each step. Problems with the supply of medicines and how information is transferred put people at increased risk of harm when they change from one healthcare setting to another.

The admission process for patients new to the home or returning to the home after receiving hospital care was reviewed. Staff advised that robust arrangements were in place to ensure that they were provided with a current list of the patient's medicines and this was shared with the GP and community pharmacist.

3.3.5 What arrangements are in place to ensure that staff can identify, report and learn from adverse incidents?

Occasionally medicines incidents occur within homes. It is important that there are systems in place which quickly identify that an incident has occurred so that action can be taken to prevent a recurrence and that staff can learn from the incident. A robust audit system will help staff to identify medicine related incidents.

Management and staff were familiar with the type of incidents that should be reported. The medicine related incidents which had been reported to RQIA since the last inspection were discussed. There was evidence that the incidents had been reported to the prescriber for guidance, investigated and the learning shared with staff in order to prevent a recurrence.

The audits completed at the inspection indicated that medicines were being administered as prescribed.

3.3.6 What measures are in place to ensure that staff in the home are qualified, competent and sufficiently experienced and supported to manage medicines safely?

To ensure that patients are well looked after and receive their medicines appropriately, staff who administer medicines to patients must be appropriately trained. The registered person has a responsibility to check that they staff are competent in managing medicines and that they are supported. Policies and procedures should be up to date and readily available for staff reference.

There were records in place to show that staff responsible for medicines management had been trained and deemed competent. Ongoing review was monitored through supervision sessions with staff and at annual appraisal.

4.0 Quality Improvement Plan/Areas for Improvement

	Regulations	Standards
Total number of Areas for Improvement	11*	6*

* the total number of areas for improvement includes seventeen which are carried forward for review at the next inspection.

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

Quality Improvement Plan

Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 14 (2) (a) **Stated:** Second time **To be completed by:** 29 July 2024	The registered person shall ensure that all parts of the home to which patients have access are free from hazards to their safety.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref**: Regulation 20 (1) (c) (i) **Stated:** First time **To be completed by** 29 August 2024	The registered person shall ensure that mandatory training requirements are met to enable staff to meet the needs of patients safely and effectively.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 3 **Ref:** Regulation 14 (4) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall make arrangements, by training staff or by other measures, to prevent patients from being harmed or suffering abuse or being placed at risk of harm or abuse. This area for improvement is made with specific reference to ensuring that staff training in manual handling practices is embedded into practice.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 4 **Ref:** Regulation 13 (1) (a) (b) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure that staff manage falls in keeping with best practice and the homes' own policies and procedures.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.

Area for improvement 5 **Ref:** Regulation 16 (2) (b) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure that the patients in the Copeland Suite with care plans regarding the locked unit have their care plan reviewed in line with deprivation of liberty safeguards.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 6 **Ref:** Regulation 13 (1) (b) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure that patients who are identified as being at risk of choking are appropriately supervised at mealtimes in keeping with their assessed needs and plan of care.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 7 **Ref:** Regulation 13 (8) (a) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall make suitable arrangement to ensure that the home is conducted in a manner which does not potentially impact on the well-being and dignity of patients. This area for improvement is made with specific reference to the following: • the provision of suitable cups, glassware and crockery • the availability of appropriate clothing protectors • staff adopting a person centred care approach and speaking about patients in a manner that is sensitive and understanding of their needs.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 8 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure staff have access to appropriate personal protective equipment and are trained in how and when to use it.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.

Area for improvement 9 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure staff adhere to regional infection prevention control guidelines regarding being bare below the elbow. A system should be implemented to monitor staff compliance with this best practice guidance.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 10 **Ref**: Regulation 24 (3) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure that all complaints are managed in keeping with this standard and appropriate records are retained. Retrospective records should be completed for any identified complaints.
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 11 **Ref**: Regulation 10 (1) **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure that there is a robust system of governance in place, that it is effective and proactive in identifying shortfalls and driving improvements through clear action planning**.**
	Action required to ensure compliance with this regulation was not reviewed as part of this inspection and this is carried forward to the next inspection.
Action required to ensure compliance with the Care Standards for Nursing Homes (December 2022)	
Area for improvement 1 **Ref:** Standard 12 **Stated:** Second time **To be completed by:** 29 July 2024	The registered person shall ensure that a daily menu is on display in a suitable format and in an appropriate location, showing patients what is available each mealtime.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 2 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 29 July 2024	The registered person shall ensure records are kept of all staff working in the home over a 24-hour period. The capacity in which they are working and the name of the nurse in charge of each shift should be clearly identified.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.

Area for improvement 3 **Ref**: Standard 41 **Stated:** First time **To be completed by:** 29 October 2024	The registered person shall ensure that staff meetings take place on a regular basis, at a minimum quarterly. Separate staff meeting minutes should be retained for the nursing home.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 4 **Ref**: Standard 4 **Stated:** First time **To be completed by** 29 July 2024	The registered person shall ensure that repositioning records evidence the delivery of pressure area care and skin checks as prescribed in the patients care plan. These records should be accurately completed.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 5 **Ref**: Standard 4.9 **Stated:** First time **To be completed by** 29 July 2024	The registered person shall ensure that a contemporaneous record is maintained of actions taken and discussion held regarding patients care and treatment. This area for improvement is mad with specific reference to management of patients with reduced fluid intake.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.
Area for improvement 6 **Ref**: Standard 37.4 **Stated:** First time **To be completed by** 29 July 2024	The registered person shall ensure that patients' fluid intake over a 24-hour period is reviewed by a registered nurse where appropriate and accurate records are maintained.
	Action required to ensure compliance with this standard was not reviewed as part of this inspection and this is carried forward to the next inspection.

The Regulation and Quality Improvement Authority

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James House
2-4 Cromac Avenue
Gasworks
Belfast
BT7 2JA

Tel: 028 9536 1111

Email: info@rqia.org.uk

Web: www.rqia.org.uk

Twitter: @RQIANews