Unannounced Care Inspection Report
13 February 2017

Edgewater Lodge

Type of Service: Nursing Home
Address: Copeland and Lighthouse Suites, 4 Sunnydale Avenue, Donaghadee, BT21 0LE
Tel no: 028 9188 8044
Inspector: Heather Sleator

1.0 Summary

An unannounced inspection of Edgewater Lodge (Copeland and Lighthouse suites) took place on 13 February 2017 from 09.40 to 16.30 hours.

The inspection sought to assess progress with any issues raised during and since the last care inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

There was evidence of the safe delivery of care. Staff were required to attend mandatory training and the observation of care delivery evidenced that knowledge and skill gained, through training, was embedded into practice. Staff had completed a number of dementia specific training areas; this was good practice and should continue.

Staffing arrangements were satisfactory. Staff confirmed communication in the home was good and that there was a system of annual appraisal and supervision in place. There was evidence of an improvement of the internal environment, particularly in Lighthouse suite. There were no requirements or recommendations made in this domain.

Is care effective?

Weaknesses have been identified in the delivery of effective care specifically in relation to care planning regarding the management of hydration for patients assessed as being at risk of dehydration. Weaknesses were also identified in the completion of patients' progress records regarding hydration by nursing staff. Improvements were also required in the management of and approach to meals and mealtimes, particularly in Lighthouse suite and the provision of mid-morning and mid afternoon tea and snacks in Copeland suite. Four recommendations have been made in this domain.

Is care compassionate?

Staff interactions with patients were observed to be caring and timely. Staff demonstrated a detailed knowledge of patients' wishes and preferences. There was evidence of good communication in the home between staff and patients and patients' were very praiseworthy of staff. Discussion with the personal activities leader (PAL) evidenced that there was a planned approach to activities and that activities staff recognised the importance of spending individual time with patients who were unable to or choose not to participate in group activities. There were no requirements or recommendations made in this domain.

Is the service well led?

There was a clear organisational structure and staff were aware of their roles and responsibilities. A review of care confirmed that the home was operating within their registered categories of care, in accordance with their Statement of Purpose and Patient Guide.

There was evidence that effective management systems had been established in the home and that the services provided by the home were regularly monitored. The registered manager had been in post the home in February 2016 and evidence was present of an improvement in the governance and management arrangements in the home. There were no requirements or recommendations made in this domain.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	4

Details of the Quality Improvement Plan (QIP) within this report were discussed with Vera Ribeiro, Registered Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent inspection

The most recent inspection of the home was an unannounced medicines management inspection undertaken on 2 February 2017. There were no further actions required to be taken following the most recent inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

2.0 Service details

Registered organisation/registered person: Four Seasons Health Care Dr Claire Royston	**Registered manager:** Vera Ribeiro
Person in charge of the home at the time of inspection: Vera Ribeiro	**Date manager registered:** 9 June 2016
Categories of care: NH-DE, NH-I, NH-PH, NH-PH (E), NH- TI	**Number of registered places:** 37

3.0 Methods/processes

Prior to inspection we analysed the following information:

- notifiable events submitted since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plans (QIPs) from inspections undertaken in the previous inspection year
- the previous care inspection report
- pre inspection assessment audit

During the inspection, care delivery/care practices were observed and a review of the general environment of the home was undertaken. The inspector also met with 20 patients, three care staff, two registered nurses, ancillary staff and a personal activities leader (PAL).

A poster indicating that the inspection was taking place was displayed on the front door of the home and invited visitors/relatives to speak with the inspectors.

Questionnaires for patients (10), relatives (eight) and staff (10) to complete and return were left for the home manager to distribute. Please refer to section 4.5 for further comment.

The following were examined during the inspection:

- validation evidence linked to the previous QIP
- staff roster
- staff training records
- staff induction records
- staff competency and capability assessments
- staff recruitment records
- staff supervision and appraisal planner
- complaints and compliments records
- incident and accident records
- records of quality audits and
- records of staff, patient and relatives meetings
- three patient care records

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 2 February 2017

The most recent inspection of the home was an unannounced medicines management inspection. There were no requirements or recommendations made as a result of the inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 19 May 2016

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref**: Regulation 12 (1) (b) and (c) **Stated:** First time	The registered person must ensure the environment of the home; in particular, Lighthouse unit reflects current best practice guidelines for dementia care. A dementia audit should be completed and an action plan developed and implemented based on the findings of the audit.	**Met**
	Action taken as confirmed during the inspection: Evidence was present that a number of dementia audits were completed following the previous inspection of 19 May 2016. Action plans were developed as a result of the completed audits. Evidence was present in Lighthouse suite of the improvement in the environment. Redecoration of the lounge and corridor areas took place and some furniture was purchased and/or refurbished. As discussed with the registered manager further improvement is required in the dining room however an improvement in the appearance of the environment was evident.	
Requirement 2 **Ref:** Regulation 13 (1) (a) and (b) **Stated:** First time	The registered person must ensure that the dining experience for patients, particularly in Lighthouse unit, reflects current best practice guidelines for dementia care. The home manager must ensure staff adheres to best practice guidelines at all times.	**Met**
	Action taken as confirmed during the inspection: Observation of the serving of the midday meal in Lighthouse suite evidenced that there had been an improvement in respect of the patients' dining experience. Dining tables were appropriately set and the meal was not rushed in any manner. Discussion took place with the registered manager regarding observations of the mealtime; refer to section 4.4 for further information.	

Requirement 3 **Ref:** Regulation 20 (1) (c) (i) **Stated:** First time	The registered person must ensure that an on-going programme of staff training in relation to dementia practice is undertaken by staff and a robust system is established that evidences training undertaken by staff is embedded into practice.	**Met**
	Action taken as confirmed during the inspection: The review of the staff training record evidenced that 97 percent of staff had completed the online training module in dementia. Further training undertaken by staff, delivered by a trainer from the organisation included; the resident experience, distressed reactions, meaningful activities and the deprivation of liberty standards.	
Last care inspection recommendations		**Validation of compliance**
Recommendation 1 **Ref:** Standard 40 **Stated:** First time	The registered person should ensure that the planned programme of staff annual appraisal and supervision is viewed as apriority and that there is a systematic approach to the completion of the programme of staff annual appraisal and regular recorded supervision.	**Met**
	Action taken as confirmed during the inspection: In discussion with staff it was confirmed that staff received an annual appraisal and that individual supervision had taken place. The review of the supervision planner for 2017 confirmed that the registered manager had established a systematic approach to staff supervision and appraisal for the 2017 year.	
Recommendation 2 **Ref:** Standard 4.10 **Stated:** First time	The registered person should ensure that a robust system regarding the auditing of patients care records is established and where a shortfall is identified the care record is re-audited to ensure that remedial action has taken place.	**Met**
	Action taken as confirmed during the inspection: Governance systems, including completed audits were reviewed. There was evidence present within completed audits that where a shortfall had been identified remedial action had taken place. The outcomes of any audits completed are reviewed and reported on during the monthly quality monitoring visit and report completed by the registered manager.	

Recommendation 3 **Ref:** Standard 37.1 **Stated:** First time	The registered person should ensure that any record retained in the home which details patient information is stored safely and in accordance with DHSSPS policy, procedures and guidance and best practice standards.	**Met**
	Action taken as confirmed during the inspection: Observation of the supplementary care records maintained by care staff evidenced that all records were stored safely and securing and were not readily accessible by other patients and/or visitors.	
Recommendation 4 **Ref:** Standard 44.2 **Stated:** First time	The registered person should ensure that the outside area visible from the dining room and some bedrooms in Copeland unit is cleared and/or screened off from patients view.	**Met**
	Action taken as confirmed during the inspection: The outside area was viewed from the patients' dining rooms and relevant bedrooms in Copeland suite. The outside area where bins were kept had been fenced and patients no longer had a clear view of the bins from these locations.	

4.3 Is care safe?

The registered manager confirmed the planned daily staffing levels for the home, and that these levels were subject to regular review to ensure the assessed needs of the patients were met. Review of the staffing rota from 13 February to 26 February 2017, evidenced that the planned staffing levels were adhered to. In the absence of the registered manager a registered nurse is designated as the person in charge of the home. Competency and capability assessments for the nurse in charge of the home were current and reflected the responsibilities of the position. Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty. Discussion with patients and staff evidenced that there were no concerns regarding staffing levels.

Discussion with staff and a review of the staff training records confirmed that training had been provided in all mandatory areas and this was kept up to date. A review of staff training records confirmed that staff completed e-learning (electronic learning) modules on a range of topics including; medicines management, fire safety, food safety, health and safety, infection prevention and control, moving and handling and adult prevention and protection from harm. The registered manager stated staff compliance with mandatory training was 97 percent.
A requirement of the previous inspection of 19 May 2016 was that staff undertook training to enhance their knowledge and skills in dementia care. The review of staff training records evidenced that staff had completed dementia specific training in areas including; the resident experience, meaningful activities, the dining experience and responding to distressed reactions.

Staff in the home had recently commenced the organisations 'Dementia Care Framework' training which aims to enhance the quality of care and life experience for persons living with dementia. Individual staff members have either completed, or are in the process of completing; dementia specific training in for example; communication, meaningful activities and all staff completed the initial training which focused on understanding dementia.

Discussion with the registered manager and staff confirmed that there were systems in place to monitor staff performance or to ensure that staff received support and guidance. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals.

The staff consulted with were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. The complaints and safeguarding records provided evidence of incidents. A review of the records identified that concerns had been logged appropriately. A review of documentation confirmed that any potential safeguarding concern was managed appropriately and in accordance with the regional safeguarding protocols and the home's policies and procedures. RQIA were notified appropriately.

A range of risk assessments were completed as part of the admission process and were reviewed as required. The assessments included where patients may require the use of a hoist or assistance with their mobility and their risk of falling; the use of bedrails, if appropriate and assistance with eating and drinking due to the risk of malnutrition or swallowing difficulties. The risk assessments generally informed the care planning process. Refer to section 4.4 for further detail regarding hydration.

A review of the accident and incident records confirmed that the falls risk assessments and care plans were completed following each incident. Care management and patients' representatives were notified appropriately.

A review of the home's environment was undertaken and included a number of bedrooms, bathrooms, shower and toilet facilities, sluice rooms, storage rooms and communal areas. In general, the areas reviewed were found to be clean and tidy. A programme of redecoration had taken place and an improvement in the appearance of the environment was evident. Issues which had been identified at the inspection of 19 May 2016 regarding the clear visibility of the bin area from the dining room and some bedrooms in Copeland suite had been addressed with fencing. Infection prevention and control measures were adhered to and equipment was stored appropriately. Fire exits and corridors were maintained clear from clutter and obstruction.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	**Number of recommendations**	0

4.4 Is care effective?

Review of patient care records evidenced that a range of validated risk assessments were completed as part of the admission process and reviewed as required. There was evidence that registered nurses, assessed, planned, evaluated and reviewed care, with one exception. Care records did not evidence a desired daily fluid target for those patients assessed as being at risk of dehydration. Care plans should have evidenced the desired daily fluid intake for

individual patients and the action to be taken, and at what stage, should the desired target not be met. A recommendation has been made.

Supplementary care charts such as repositioning and food and fluid intake records evidenced that care was delivered and records were maintained in accordance with best practice guidance, care standards and legislative requirements. Repositioning charts evidenced the frequency of repositioning and there were no obvious 'gaps' in recording. A consistent approach to the recording of patients' fluid intake was evidence. There was no evidence that the registered nurses were reviewing the fluid intake of patients within the progress record in patient care records. A recommendation has been made.

There was evidence that the care planning process included input from patients and/or their representatives, if appropriate. There was evidence of regular communication with representatives within the care records.

The observation of the midday meal in the Lighthouse suite evidenced that further improvement was needed. The dining room appeared 'small', perhaps due to the number of patients who were wheelchair users or were sitting in specialised seating. Discussion took place with the registered manager regarding this and it was agreed that consideration would be given to alternative arrangements, for example; having two sittings at the midday and evening mealtimes. The day's menu was not displayed in a suitable format or location for persons living with dementia. This was discussed with the registered manager who stated they were sourcing a method of displaying the day's menu which would be easily read by patients. It was unclear as to whether patients' who required a modified diet were afforded a choice at mealtimes. A patient was observed having a meal which was not as was stated on the menu choice record. Staff felt the meal given would be easier for the patient to eat. Staff should be able to assist patients with limited verbal communication regarding their menu choice through knowledge of individuals' likes and dislikes. Patients were observed to be given a cup of tea either with their meal or before their meal was served. This was discussed with the registered manager who stated she had been informed this was patients choice. It is preferable to offer patients a choice of fluids with their meal. The tea which was observed being given to patients was in a white cup without a saucer. The registered manager should review the suitability of the crockery in use to ensure it is the most appropriate crockery for persons living with dementia. Crockery should provide patients with a clear colour contrast to enhance patients' vision of the crockery and therefore their independence. A recommendation has been made that the dining experience in Lighthouse suite is reviewed and enhanced so as it is a pleasurable activity for persons living with dementia.

We observed the serving of the mid-morning tea and snack in Copeland suite. Patients did not have a choice of beverage as only tea was available. Staff stated juice was available in the lounge areas and patients bedrooms. There was evidence of the communal use of a thickening agent for those patients with swallowing difficulties, as only one container of thickening agent was on the tea trolley. Patients who required a modified diet received a cup of tea and no snack. Staff stated this was because the kitchen had 'run out' of yoghurts. A recommendation has been made that the mid-morning and mid afternoon tea service affords patients a choice of fluid and patients who require a modified diet have a choice of an appropriate snack, at all times.

Areas for improvement

Care plans should have evidenced the desired daily fluid intake for individual patients and the action to be taken, and at what stage, should the desired target not be met.

Evidence should be present that the registered nurses review the fluid intake of patients within the progress record in patient care records.

The dining experience for patients in the Lighthouse suite should be reviewed and enhanced so as it is a pleasurable activity for persons living with dementia.

The mid-morning and mid afternoon tea service should afford patients a choice of fluid and patients who require a modified diet should have a choice of an appropriate snack.

Number of requirements	0	Number of recommendations	4

4.5 Is care compassionate?

Staff interactions with patients were observed to be compassionate, caring and timely.

Staff demonstrated a detailed knowledge of patients' wishes and preferences. Staff were also aware of the requirements regarding patient information, confidentiality and issues relating to consent. Discussion with one of the personal activities leaders (PAL) evidenced that there was a range of planned activities mainly on Monday to Friday. Opportunities for patients to visit community facilities continue and many external entertainers come to home for social events. Observation of the activities at the time of the inspection evidenced staffs knowledge of the importance of spending individual time with those patients who are unable to participate in more formal or group activities. This was good practice.

Discussion with the registered manager confirmed that there were systems in place to obtain the views of patients, their representatives and staff on the running of the home. Views and comments of the patients and relatives are sought using the organisations electronic quality of life questionnaire. The most recent relatives meetings for both Copeland and Lighthouse suites were in January 2017. There was evidence that the registered manager had actioned or was trying to action issues raised by relatives at the meetings. A newsletter had also been developed, to share information of events and planned activities, with patients and relatives.

Consultation with patients individually, and with others in smaller groups, confirmed that living in Copeland and Lighthouse suites was, in general, a positive experience.

Comments received from patients include:
"They do their best."
"I'm very content."
"The nursing staff are marvellous."
"Care staff are very friendly and spend time and talk to me"

Comments from staff included:
"Well run home"
"Good place to work, well supported"
"I enjoy working here"

Questionnaires

In addition (10) relative/representatives; (eight) patient and (10) staff questionnaires were provided by RQIA to the registered manager for distribution. At the time of issuing this report five staff members had returned their questionnaires within the specified timeframe.

The responses within the returned questionnaires were positive in respect of the care and attention afforded to patients and the quality of nursing and other services provided by the home. However, one staff member did comment that, “unless we are short staff there is just enough staff to meet the needs of the patients; lately it is a heavy unit and doesn’t leave much time to stop and talk to the patients.”

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff were able to describe their roles and responsibilities. In discussion, representatives were aware of the roles of the staff in the home and whom they should speak to if they had a concern.

The registration certificate was displayed in the entrance lobby. A certificate of public liability insurance was current and displayed.

Discussion with the registered manager and review of the home’s complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Staff confirmed that they were confident that staff and management would manage any concern raised by them appropriately. A patient contacted RQIA following the inspection and discussed a number of concerns that they had. Agreement was sought from the patient that we would inform the registered manager of the concerns and ask that the registered manager investigate the concerns. This was done and the patient subsequently contacted RQIA to confirm the concerns raised had been addressed and that they were satisfied with the outcome to the concerns raised.

Discussion with the registered manager and review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to RQIA or other relevant bodies appropriately. A review of notifications of incidents to RQIA since the last care inspection in May 2016 confirmed that these were managed appropriately.

Discussion with the registered manager and review of records evidenced that systems were in place to monitor and report on the quality of nursing and other services provided. For example, audits were completed in relation to care records, infection prevention and control, incidents and accidents. The outcome of any audit undertaken is reviewed on a monthly basis by the regional manager when completing the monthly quality monitoring visit and subsequent report.

Discussion with the registered manager and review of records for November and December 2016 and January 2017 evidenced that Regulation 29 monthly quality monitoring visits were completed in accordance with the regulations and/or care standards. An action plan was generated to address any areas for improvement.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	0	Number of recommendations	0

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Vera Ribeiro, Registered Manager, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to web portal for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Recommendations	
Recommendation 1 **Ref:** Standard 4.8 **Stated:** First time **To be completed by:** 17 March 2017	The registered provider should ensure care plans evidence the desired daily fluid intake for individual patients and the action to be taken, and at what stage, should the desired target not be met. **Ref: section 4.4** **Response by registered provider detailing the actions taken:** Supervisions have been completed with nursing staff to ensure care plans reflect individuals desired fluid intake and actions to be taken when target is not met. Registered Nurses total daily fluid balance charts and note in the Care Plan evaluation any variance in the recommended daily fluid target. If this target is not met for more than two consecutive days or 3 days during the same week advise will be sought from the residents GP. The Registered Manager and Deputies will ensure compliance through regular auditing and spot checks and any identified actions will be addressed at this time.
Recommendation 2 **Ref:** Standard 4.8 **Stated:** First time **To be completed by:** 17 March 2017	The registered provider should ensure that registered nurses monitor the daily fluid intake of patients assessed as being at risk of dehydration. **Ref: section 4.4** **Response by registered provider detailing the actions taken:** Supervision carried with Nursing staff to ensure their awareness for completion and monitor the daily fluid intake of patients assessed as being at risk of dehydration. Daily fluild intake for these patients to be written on 24 hours shift report on a daily basis.
Recommendation 3 **Ref:** Standard 12.21 **Stated:** First time **To be completed by:** 3 April 2017	The registered provider should ensure that the dining experience for patients in the Lighthouse suite is reviewed and enhanced so as it is a pleasurable activity for persons living with dementia. **Ref: section 4.4** **Response by registered provider detailing the actions taken:** Alternative options to be trialed in order to enhace residents experience Residents and theirs families will be consulted in order to make a decision ensuring changes will transform positively resident experience. FSHC Dining audit will be carried and action plan implemented, meals and mealtimes will continue to be observed to ensure dining experience remains positive and pleasurable.

Recommendation 4 **Ref:** Standard 12.15 **Stated:** First time **To be completed by:** 17 March 2017	The registered provider should ensure that the mid-morning and mid afternoon tea service affords patients a choice of fluid and patients who require a modified diet should have a choice of an appropriate snack. **Ref: section 4.4**
	Response by registered provider detailing the actions taken: Discussion with catering staff on preparation of mid-morning and afternoon tea service trolleys to always ensure residents will have different options of fluids and a choices for residents on modified diet. Register Manager and nurse in charge of each unit will monitor and address any identified issues.

Please ensure this document is completed in full and returned via web portal

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews