Inspection Report
10 November 2020

Edenvale Care Home

Type of Service: Nursing Home
Address: 1-7 Edenmore Road, Limavady, BT49 0RF
Tel No: 028 7772 2055
Inspector: Paul Nixon

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 this inspection and do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

Information relating to our inspection framework, the guidance and legislation that informs the inspections, the four domains which we assess services against as well as information about the methods we use to gather opinions from people who have experienced a service can be found at https://www.rqia.org.uk/guidance/legislation-and-standards/ and https://www.rqia.org.uk/guidance/guidance-for-service-providers/

1.0 Profile of service

This is a registered nursing home which provides care for up to 55 patients.

2.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager and date registered:** Mrs Anne O'Kane 16 June 2020
Person in charge at the time of inspection: Mrs Anne O'Kane	**Number of registered places:** 55 A maximum of 21 patients in category NH-DE, two patients in category NH-MP, two patients in category NH-MP(E), four patients in category NH-PH, one patient in category NH-LD and six patients in category NH-TI.
Categories of care: Nursing Home (NH) I – Old age not falling within any other category DE – Dementia MP – Mental disorder excluding learning disability or dementia MP (E) - Mental disorder excluding learning disability or dementia – over 65 years LD – Learning disability PH – Physical disability other than sensory impairment PH (E) - Physical disability other than sensory impairment – over 65 years TI – Terminally ill	**Number of patients accommodated in the nursing home on the day of this inspection:** 29

3.0 Inspection focus

This announced inspection was undertaken by a pharmacist inspector on 10 November 2020 from 09.50 to 13.20. Short notice of the inspection was provided to the registered manager in order to ensure that arrangements could be made to safely facilitate the inspection in the home.

There were no patients occupying the ground floor of the home, where renovation work was being carried out.

This inspection focused on medicines management within the home. The inspection also assessed progress with any areas for improvement identified at or since the last care inspection.

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous inspections findings, registration information, and any other written or verbal information received.

During our inspection we:

- spoke to staff and management about how they plan, deliver and monitor the care and support provided in the home
- observed practice and daily life
- reviewed documents to confirm that appropriate records were kept.

A sample of the following records was examined and/or discussed during the inspection:

- personal medication records
- medicine administration
- medicine receipt and disposal
- controlled drug records
- care plans related to medicines management
- hand hygiene audits
- governance and audit
- staff training and competency
- medicine storage temperatures
- RQIA registration certificate

4.0 Inspection Outcome

	Regulations	Standards
Total number of areas for improvement	0	0

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

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

5.0 What has this service done to meet any areas for improvement identified at or since the last care inspection on 20 August 2020?

Areas for improvement from the last care inspection		
Action required to ensure compliance with The Nursing Homes Regulations (Northern Ireland) 2005		**Validation of compliance**
Area for improvement 1 **Ref**: Regulation 14 (2) **Stated:** First time	The registered person shall ensure as far as reasonably practicable that all parts of the home to which patients have access are free from hazards to their safety. With specific reference to: • denture cleaning tablets • prescribed supplements • identified trip hazard from nurse call lead • chemicals to be labelled and include the date of preparation	**Met**
	Action taken as confirmed during the inspection: The hazards had been negated. Denture cleaning tablets were stored in a locked cupboard in the treatment room. Prescribed supplements were in a locked store. There were no trailing cables observed. Chemicals were appropriately labelled and included the date of preparation.	
Action required to ensure compliance with the Department of Health, Social Services and Public Safety (DHSSPS) Care Standards for Nursing Homes (2015)		**Validation of compliance**
Area for improvement 1 **Ref**: Standard 28 **Stated:** First time	The registered person shall ensure that the regular administration of medicines which are prescribed for occasional/"when required" use, is referred to the prescriber for review.	**Met**
	Action taken as confirmed during the inspection: The registered manager provided evidence that the general medical practitioners (GPs) had been requested to review medicines prescribed for occasional/"when required" use but which were being regularly administered. She stated that this was kept under review on an ongoing basis.	

Area for improvement 2 **Ref**: Standard 4 **Stated:** First time	The registered person shall ensure that daily evaluation notes, care plans and risk assessments are reviewed to reflect the current needs of the patient. This is in specific reference to ensuring that: • care plans accurately reflect the patients pain management • care plans accurately reflect the management of distressed reactions • daily evaluation notes contain clear information regarding reasons for administering "when required" medication for pain, constipation and distressed reactions • risk assessments are reviewed monthly or more often if required.	**Met**
	Action taken as confirmed during the inspection: The care plans, risk assessments and daily evaluation notes were reviewed for two patients who were prescribed medication for administration on a "when required" basis for the management of distressed reactions. These records had been appropriately maintained. The care plans and pain assessments were reviewed for three patients who were prescribed regular analgesia. These records had also been appropriately maintained. Review of several patients' daily notes confirmed that the reasons for administering "when required" medication for pain and constipation were generally recorded. Risk assessments were reviewed on a monthly basis.	

Area for improvement 3 **Ref**: Standard 35 **Stated:** First time	The registered person shall ensure that robust quality assurance audits are maintained to assess the delivery of care in the home. With specific reference to: • Hand hygiene audits	**Met**
	Action taken as confirmed during the inspection: Where full compliance was not achieved in the hand hygiene audits there was now an explanation or action plan to address the deficits. There was evidence of staff supervisions regarding deficits observed during the audits.	

6.0 What people told us about this service

Observation of the delivery of care evidenced that staff attended to patients needs in a timely and caring manner. Staff were warm and friendly and obviously knew the patients well. The home was observed to be clean and warm; there were no malodours. Corridors were free from trip hazards.

Staff spoken to expressed satisfaction with how the home was managed and with their training opportunities. They said that management was supportive and responsive to any suggestions or concerns raised.

Feedback methods also included a staff poster and paper questionnaires which were provided to the registered manager for any patient or their family representative to complete and return using pre-paid, self-addressed envelopes. No questionnaires were completed within the timeframe for inclusion in this report.

7.0 Inspection findings

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

Patients in nursing homes should be registered with a 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 the GP, the pharmacist or during a hospital admission.

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

Personal medication records were in place for each patient. These contained a list of all 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 e.g. medication reviews, transfers to hospital. The records inspected had been fully and accurately completed. In line with best practice, a second member of staff had checked and signed these records when they were updated to provide a double check that they were accurate.

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 plans 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. We reviewed the management of thickening agents for three patients. A speech and language assessment report and care plan were in place. Records of prescribing and administration which included the recommended consistency level were maintained.

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

Medicines must be available to ensure that they are administered to patients as prescribed and when they require them. It is important that they are stored safely and securely and disposed of promptly so that there is no unauthorised access.

The records inspected showed that medicines were available for administration when patients required them.

On arrival at the home the medicines storage area was observed to be securely locked. It was tidy and organised so that medicines belonging to each patient could be easily located. The medicines currently in use were stored within medicine trolleys that were also securely stored so that there could be no unauthorised access. Controlled drugs were stored in the controlled drug cabinet. When medicines needed to be stored at a colder temperature, they were stored within the medicines refrigerator and the temperature of this refrigerator was monitored each day.

Medicines disposal was discussed with the registered manager. Medicines were returned to the waste contractor regularly and were not allowed to accumulate in the home. Disposal of medicine records had been completed so that medicines could be accounted for.

7.3 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.

Within the home, a record of the administration of medicines was completed on pre-printed medicine administration records (MARs) when medicines were administered to a patient. A sample of these records was reviewed, which found that they had been fully and accurately completed. The completed MARs were filed once completed.

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 were recorded in a controlled drug record book. We found that controlled drugs were safely managed in the home and that records were accurately maintained.

The registered manager audits medicine administration on a monthly basis within the home. The audits showed that medicines had been given as prescribed. The date of opening was recorded on medicines so that they can be easily audited. This is good practice.

Audits completed during this inspection also showed that medicines had been given as prescribed.

7.4 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.

We reviewed the management of medicines for two recently admitted patients. In each instance a hospital discharge letter had been received and a copy had been forwarded to the patient's GP. Medicines had been accurately received into the home and administered in accordance with the most recent directions.

7.5 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.

The audit system in place would help staff to identify medicine related incidents. The registered manager and nurses on duty were familiar with the type of incidents that should be reported.

There had been several medication related incidents identified since the last medicines management inspection. There was evidence that the incidents had been investigated and learning had been shared with staff. The incidents had been reported to the prescribers for guidance and to the appropriate authorities including RQIA.

7.6 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 staff are competent in managing medicines and that staff are supported.

Staff in the home had received a structured induction which included medicines management when that forms part of their role. Competency had been assessed following induction and annually thereafter. A written record was completed for induction and competency assessments.

8.0 Evaluation of Inspection

This inspection sought to assess if the home was delivering safe, effective and compassionate care and if the service was well led with regards to medicines management.

The outcome of this inspection concluded that all areas for improvement identified at the last care and medicines management inspections had been addressed and no new areas for improvement were identified. The registered provider had taken the appropriate actions to ensure that any previous areas for improvement had been addressed and improvements were sustained.

We can conclude that patients and their relatives can be assured that medicines are well managed within the home.

We would like to thank the patients and staff for their assistance throughout the inspection.

9.0 Quality improvement plan

There were no areas for improvement identified during this inspection, and a QIP is not required or included, as part of this inspection report.

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