Unannounced Care Inspection Report
4 June 2019

Edenvale Care Home

Type of Service: Nursing Home
Address: 1-7 Edenmore Road, Limavady, BT49 0RF
Tel No: 02877722055
Inspector: Michael Lavelle

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 service from their responsibility for maintaining compliance with legislation, standards and best practice.

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.

1.0 What we look for

2.0 Profile of service

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

3.0 Service details

Organisation/Registered Provider: Four Seasons Health Care **Responsible Individual:** Dr Maureen Claire Royston	**Registered Manager and date registered:** Anne O'Kane Acting no application required
Person in charge at the time of inspection: Anne O'Kane	**Number of registered places:** 55 A maximum of 21 patients in category NH-DE, 2 patients in category NH-MP, 2 patients in category NH-MP(E), 4 patients in category NH-PH, 1 patient in category NH-LD and 6 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:** 42

4.0 Inspection summary

An unannounced inspection took place on 4 June 2019 from 07.45 to 16.20.

The inspection assessed progress with any areas for improvement identified 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.

Evidence of good practice was found in relation to staffing, training, supervision and appraisal and communication between patients, staff and other key stakeholders. Further areas of good practice were found in relation to the culture and ethos of the home, governance arrangements, management of incidents, quality improvement and maintaining good working relationships.

No areas requiring improvement were identified.

Patients described living in the home in positive terms. Residents unable to voice their opinions were seen to be relaxed and comfortable in their surrounding and in their interactions with staff.

Comments received from patients, people who visit them and professionals and staff during the inspection, are included in the main body of this report.

The findings of this report will provide the home with the necessary information to assist them to fulfil their responsibilities, enhance practice and patients' experience.

4.1 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 Anne O'Kane, 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.

4.2 Action/enforcement taken following the most recent inspection dated 16 August 2018

The most recent inspection of the home was an unannounced care inspection. Other than those actions detailed in the QIP no further actions were required to be taken. Enforcement action did not result from the findings of this inspection.

5.0 How we inspect

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

During our inspection we:

- where possible, speak with patients, people who visit them and visiting healthcare professionals about their experience of the home
- talk with staff and management about how they plan, deliver and monitor the care and support provided in the home
- observe practice and daily life
- review documents to confirm that appropriate records are kept

Questionnaires and 'Have We Missed You' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with views of the home. A poster was provided for staff detailing how they could complete an electronic questionnaire. A poster indicating that an inspection was taking place was displayed at the entrance to the home.

The following records were examined during the inspection:

- duty rota for all staff from weeks beginning 3 June 2019 and 10 June 2019
- records confirming registration of staff with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC)
- staff training records
- incident and accident records
- one staff recruitment/induction file and agency staff induction records
- five patient care records
- a selection of patient care charts including food and fluid intake charts and reposition charts
- a sample of governance audits/records
- environment and equipment cleaning records
- complaints record
- compliments received
- minutes of staff meetings and patient meetings
- patient satisfaction survey
- fire drill records and uptake
- staff supervision and appraisal planner
- a sample of reports of visits by the registered provider
- RQIA registration certificate

Areas for improvement identified at the last care inspection were reviewed and assessment of compliance recorded as either met, partially met, or not met.

The findings of the inspection were provided to the person in charge at the conclusion of the inspection.

6.0 The inspection

6.1 Review of areas for improvement from the most recent inspection dated 16 August 2018

Areas of improvement identified at previous care inspection have been reviewed and are met.

6.2 Inspection findings

6.3 Is care safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them.

We arrived at the home at 07.45 and were greeted by the manager who was friendly and welcoming. They 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.

A review of the staffing rota for weeks commencing 3 June 2019 and 10 June 2019 evidenced that the planned staffing levels were adhered to. Rotas also confirmed that catering and housekeeping staff were on duty daily to meet the needs of the patients and to support the nursing and care staff.

Observation of the delivery of care evidenced that patients' needs were met by the levels and skill mix of staff on duty and that staff attended to patient's needs in a timely manner. Staff spoken with were satisfied that there was sufficient staff on duty to meet the needs of the patients. Patients spoken with indicated that they were well looked after by the staff and felt safe and happy living in Edenvale Care Home.

Review of one staff recruitment file confirmed staff were recruited in accordance with relevant legislation and mandatory requirements. Appropriate pre-employment checks were completed and recruitment processes included the vetting of applicants to ensure they were suitable to work in the patients in the home.

Staff spoken with said they completed a period of induction alongside a mentor and they would actively support new staff during their induction to the home. Review of records confirmed that a comprehensive induction was given to one recently recruited employee and agency staff who work in the home. Review of records evidenced the manager had a robust system in place to monitor staffs registration with their relevant professional bodies.

Review of records and discussion with staff and the manager confirmed that systems were in place to ensure receive staff training, supervision and appraisal.

Staff spoken with were knowledgeable regarding their roles and responsibilities in relation to adult safeguarding and their duty to report concerns. Discussion with the manager confirmed that the regional operational safeguarding policy and procedures were embedded into practice. Systems were in place to collate the information required for the annual adult safeguarding position report.

We reviewed accidents/incidents records since January 2019 in comparison with the notifications submitted by the home to RQIA. Records were maintained appropriately and notifications were submitted in accordance with regulation.

Records confirmed that on at least a monthly basis falls occurring in the home were analysed to identify if any patterns or trends were emerging. If required, an action plan was devised to address any identified deficits. This information was also reviewed as part of the monthly monitoring visits.

Observation of practices, discussion with staff and review of records evidenced that infection prevention and control measures were generally well adhered to. Staff were knowledgeable in relation to best practice guidance with regards to hand hygiene and use of personal protective equipment (PPE) and were observed to wash their hands, use alcohol gels and use PPE at appropriate times. Environmental cleaning records were reviewed and were well completed. We discussed the storage of commodes in bathrooms with the manager. This practice should be reviewed.

A review of records evidenced that appropriate risk assessments had been completed prior to the use of restrictive practices. There was also evidence of consultation with patients, their families. Care plans were in place for the management of restrictive practices including bedrails However, review of care records for one identified patient evidenced that a care plan for the use of bedrails did not accurately reflect the appropriate period for review. This was discussed with the manager who arranged for this to be actioned before the end of the inspection

A review of the home's environment was undertaken and included observations of a sample of bedrooms, bathrooms, lounges, dining rooms and storage areas. The home was found to be warm and well decorated. The manager confirmed that refurbishment work to the bathrooms within the home is planned and the appropriate variation application will be submitted. We observed the sink to be cracked in the upstairs nurse's office. This was discussed with the manager who agreed to have this repaired.

Fire exits and corridors were observed to be clear of clutter and obstruction. Stairwells were also observed to be clear. Records evidenced that systems were in place to manage and record fire drills and fire alarm tests within the home.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to staffing, staff recruitment, induction, training, supervision and appraisal, infection prevention and control and risk management.

Areas for improvement

No areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.4 Is care effective?

The right care, at the right time in the right place with the best outcome.

Review of five patient care records evidenced that a range of validated risk assessments were completed and reviewed as required. These assessments informed the care planning process. Generally care plans were in place to direct the care required and reflected the assessed needs of the patient. We reviewed the management of infection, restrictive practices, weight loss, falls and wound care. Care records contained details of the specific care requirements in each of the areas reviewed and a daily record was maintained to evidence the delivery of care.

Review of wound management for one patient evidenced that when a wound was identified, an initial wound assessment was completed and a wound care plan developed. Care plans were reflective of tissue viability nurse (TVN) recommendations. Body maps were completed identifying the location of the wound. Photos were taken and wound observation charts completed to monitor the progress of the wound at the time of wound dressing. Evaluations were well completed.

Minor deficits were identified in relation to record keeping in one identified patients care plan in relation to bedrail management and some supplementary care records such as, eating and drinking records and repositioning records. This was discussed with the manager for action as required. This will be reviewed at a future care inspection.

We reviewed the role of the Care Home Assistant Practitioner (CHAP) in the home. Discussion with the CHAP evidenced they had a good knowledge of the patients in the home and they confirmed they always worked alongside a senior nurse. Review of the staffing rota verified this. Review of records confirmed they carried out appropriate risk assessments when required and the CHAP reported these would be reviewed by the nurse in charge.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as care manager, General Practitioners (GPs), tissue viability nurse (TVN), dietician, optician and speech and language therapists (SALT). There was evidence that care plans had been reviewed in accordance with recommendations made by other healthcare professionals.

We observed the serving of the mid-morning snacks and breakfast. Patients were assisted to the dining room and staff were observed assisting patients with their meal appropriately. Patients enjoyed the mealtime experience and were offered a choice of breakfast and drinks. Staff demonstrated their knowledge of patients' likes and dislikes regarding food and drinks, how to modify fluids and how to care for patients during mealtimes. Review of the menu evidenced that planned meals had been adhered to. The manager confirmed new pictorial menu photos had been ordered and were due to be delivered.

Discussion with staff evidenced they were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

Staff stated that there was effective teamwork; each staff member knew their role, function and responsibilities. Staff also confirmed that if they had any concerns, they would raise theses with the registered manager or the nurse in charge. When we spoke with staff they had a good knowledge of patients' abilities and level of decision making; staff know how and when to provide comfort to patients because they know their needs well.

All grades of staff consulted with demonstrated the ability to communicate effectively with their colleagues and other health care professionals.

Discussion with manager and review of records confirmed that staff meetings were held regularly and records maintained. Records also evidenced recent patient meeting held in May 2019 and minutes were available.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to communication between residents, staff and other key stakeholders.

Areas for improvement

No areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.5 Is care compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support.

Staff demonstrated a detailed knowledge of patients' wishes, preferences and assessed needs and how to provide comfort if required. Staff interactions with patients were observed to be compassionate, caring and timely. Patients were afforded choice, privacy, dignity and respect. Staff were also aware of the requirements regarding patient information and patient confidentiality.

Discussion with patients and staff and review of the activity programme displayed in the foyer evidenced that arrangements were in place to meet patients' social, religious and spiritual needs. The personal activity leader (PAL) informed us that patients and relatives had suggested a summer fete and coffee mornings at a recent patients meeting; arrangements were not in place for these events. Whilst contemporaneous records were kept by the PAL of all activities that take place, the names of the person leading them and the patients who participated gaps were identified with care planning around activities. This was discussed with the manager who confirmed that the appointment of a new PAL would support the provision of activities and required records. This will be reviewed at a future care inspection.

The environment in the home had been adapted to promote positive outcomes for the patients. Many of the bedrooms were personalised with possessions that were meaningful to the patient and reflected their life experiences.

We reviewed the patient feedback which was very positive. Consultation with 14 patients individually, and with others in smaller groups, confirmed they were happy and content living in Edenvale Care Home. Some of the patient's comments included,

"So far so good. I am getting on well."
"They take good care of me."
"It's a grand spot here."

Patients who could not verbalise their feelings in respect of their care were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

No relatives were spoken with during the inspection. Five relative questionnaires were provided; we had one anonymous response within the timescale specified. The respondent was unsatisfied or very unsatisfied across all domains with the exception of compassionate care which they were neither satisfied nor unsatisfied. Accompanying comments were as follows,

"Not enough staff from 8pm onwards. Things that happen in here shouldn't if enough staff to supervise and care for residents."

The above comment was discussed with home management post inspection for action as required.

Staff were asked to complete an online survey; we received no responses within the expected timeframe. Seven members of staff were spoken with during the inspection. Some of the comments received included the following,

"The new manager is very good."
"I am happy with the staff working here."
"The manager is firm but fair. The teamwork is great."
"I feel supported."

Any comments from patients, patient representatives and staff in returned questionnaires received after the return date were shared with the registered manager for their information and action as required.

The manager confirmed the annual quality report was due for completion in July 2019 and that quality of life reviews are ongoing with patients and relatives.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to the culture and ethos of the home, dignity and privacy, listening to and valuing patients and their representatives and taking account of the views of patients.

Areas for improvement

No areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

6.6 Is the service well led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care.

The certificate of registration issued by RQIA was appropriately displayed in the foyer of the home. Discussion with staff, and observations confirmed that the home was operating within the categories of care registered.

Since the last inspection there has been a change in management arrangements. RQIA were notified appropriately. A review of the duty rota evidenced that the manager's hours, and the capacity in which these were worked, were clearly recorded. Discussion with staff, patients and visiting professionals evidenced that the manager's working patterns supported effective engagement with patients, their representatives and the multi-professional team. Staff were able to identify the person in charge of the home in the absence of the manager.

There was evidence of good management oversight of the day to day working in the home. A number of audits were completed to assure the quality of care and services; areas audited included wounds, care plans, infection prevention and control/environment, restrictive practices, falls and accidents and incidents. Audits generated action plans that highlighted areas for improvement and there was evidence that the deficits identified were actioned as required.

Discussion with the 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. Review of records evidenced that quality monitoring visits were completed on a monthly basis on behalf of the responsible individual in accordance with the relevant regulations and standards.

Review of the home's complaints records evidenced that systems were in place to ensure that complaints were managed appropriately in line with best practice guidance. Patient's spoken with said they would be confident if they raised a complaint that it would be dealt with accordingly.

Discussion with staff confirmed that there were good working relationships and that management were supportive and responsive to any suggestions or concerns raised.

Areas of good practice

There were examples of good practice found throughout the inspection in relation to governance arrangements, management of incidents, quality improvement and maintaining good working relationships.

Areas for improvement

No areas for improvement were identified during the inspection in this domain.

	Regulations	Standards
Total number of areas for improvement	0	0

7.0 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.

The Regulation and Quality Improvement Authority

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

Tel 028 9536 1111
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews

Assurance, Challenge and Improvement in Health and Social Care