The Regulation and Quality Improvement Authority

Inspection Report

28 April 2022

Edenvale Care Home

Type of service: Nursing Home
Address: 1-7 Edenmore Road, Limavady BT49 0RF
Telephone number: 028 7772 2055

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

1.0 Service information

Organisation: Ann's Care Homes Limited **Responsible Individual :** Mrs Charmaine Hamilton	**Registered Manager:** Mrs Louisa Semple – not registered
Person in charge at the time of inspection: Mrs Louisa Semple – manager	**Number of registered places:** 55
Categories of care: Nursing Home (NH) LD – Learning disability MP – Mental disorder excluding learning disability or dementia MP(E) - Mental disorder excluding learning disability or dementia – over 65 years PH – Physical disability other than sensory impairment TI – Terminally ill DE – Dementia I – Old age not falling within any other category PH(E) - Physical disability other than sensory impairment – over 65 years.	**Number of patients accommodated in the nursing home on the day of this inspection:** 29
Brief description of the accommodation/how the service operates: This is a registered Nursing Home which provides nursing care for up to 55 persons. The home is divided into two units. Benbradagh which provides dementia nursing care on the ground floor and Binevenagh which provides general nursing care on the first floor. Patient bedrooms are located over the two floors. Patients have access to communal lounges, dining rooms and a garden.	

2.0 Inspection summary

An unannounced inspection took place on 28 April 2022 from 9.40am to 4.30pm by a care inspector. The inspection assessed progress with all areas for improvement identified in the home during the previous care inspection and considered if the home was delivering safe, effective and compassionate care and if the service was well led.

There was evidence that management had made good improvements since the last inspection. All of the previous areas for improvement had been fully addressed and no new areas for improvement were identified.

Patients were happy to engage with the inspector and share their experiences of living in the home. Patients expressed positive opinions about the home and the care provided. Patients said that staff menmbers were helpful and pleasant in their interactions with them.

Patients who could not verbally communicate were well presented in their appearance and appeared to be comfortable and settled in their surroundings.

RQIA were assured that the delivery of care and service provided in Edenvale Care Home was provided in a compassionate manner by staff who knew and understood the needs of the patients.

The findings of this report will provide the manager with the necessary information to improve staff practice and the patients' experience.

3.0 How we inspect

RQIA's inspections form part of our ongoing assessment of the quality of services. Our reports reflect how they were performing 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.

In preparation for this inspection, a range of information about the service was reviewed to help us plan the inspection.

Throughout the inspection patients, relatives and staff were asked for their opinion on the quality of the care and their experience of living or working in Edenvale Care Home. The daily life within the home was observed and how staff went about their work. A range of documents were examined to determine that effective systems were in place to manage the home.

Questionnaires and 'Tell Us' cards were provided to give patients and those who visit them the opportunity to contact us after the inspection with their views of the home. A poster was provided for staff detailing how they could complete an on-line questionnaire.

The findings of the inspection were provided to the manager at the conclusion of the inspection.

4.0 What people told us about the service

Ten patients, two relatives and five staff were spoken with. No questionnaires were returned and no feedback was received from the staff online survey.

Patients spoke positively about the care that they received and about their interactions with staff. Patients confirmed that staff treated them with dignity and respect and that they would have no issues in raising any concerns with staff. Relatives were complimentary of the care provided in the home.

Staff acknowledged the challenges of working through the COVID – 19 pandemic but all staff agreed that Edenvale Care Home was a good place to work. Staff members were complimentary in regard to the home's management team and spoke of how much they enjoyed working with the patients.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since last inspection?

Areas for improvement from the last inspection on 06 May 2021		
Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 21.1 **Stated:** First time	The registered person shall ensure care plans for the management of wounds accurately reflect recommendations of the multidisciplinary team and are updated to reflect the assessed needs of the patient. Wound assessment and evaluations should be completed in keeping with best practice guidance.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 **Ref**: Standard 12 **Stated:** First time	The registered person shall ensure patients are involved in planning the menu to ensure their preferences are considered.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

Area for improvement 3 **Ref:** Standard 4.1 **Stated:** First time	The registered person shall ensure an initial plan of care based on the pre-admission assessment and referral information is in place within 24 hours of admission. The care plans should be further developed within five days of admission, reviewed and updated in response to the changing needs of the patient.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	

5.2 Inspection findings

5.2.1 Staffing Arrangements

A review of staff selection and recruitment records evidenced that staff members were recruited safely ensuring that all pre-employment checks had been completed prior to each staff member commencing in post. Staff were provided with a comprehensive induction programme to prepare them for providing care to patients. Checks were made to ensure that staff maintained their registrations with the Nursing and Midwifery Council (NMC) and the Northern Ireland Social Care Council (NISCC).

The staff duty rota accurately reflected the staff working in the home on a daily basis. This rota identified the person in charge when the manager was not on duty. Review of records confirmed all of the staff who take charge of the home in the absence of the manager had completed a competency and capability assessment to be able to do so.

There were systems in place to ensure that staff were trained and supported to do their job. Staff consulted with confirmed that they received regular training in a range of topics such as moving and handling, infection prevention and control (IPC) and fire safety.

Review of staff training records confirmed that all staff members were required to complete adult safeguarding training on an annual basis. Staff members were able to correctly describe their roles and responsibilities regarding adult safeguarding.

Staff said they felt well supported in their role and were satisfied with the level of communication between staff and management. Staff reported good team work and had no concerns regarding the staffing levels. The manager confirmed there was ongoing recruitment for a vacant deputy manager role in the home.

Patients spoke positively about the care that they received and confirmed that staff attended to them in a timely manner; patients also said that they would have no issue with raising any concerns to staff. It was observed that staff responded to patients' requests for assistance in a prompt, caring and compassionate manner. Relatives spoken with expressed no concerns regarding staffing arrangements and were complimentary about the care delivered in the home.

5.2.2 Care Delivery and Record Keeping

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. Staff members were knowledgeable of patients' needs, their daily routine, wishes and preferences. Staff confirmed the importance of keeping one another up to date with any changing needs in patients' care throughout the day.

It was observed that staff respected patients' privacy by their actions such as knocking on doors before entering, discussing patients' care in a confidential manner and by offering personal care to patients discreetly. Staff members were observed to be prompt in recognising patients' needs and any early signs of distress, especially in those patients who had difficulty in making their wishes known. Staff members were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs.

Patients who were less able to mobilise required special attention to their skin care. These patients were assisted by staff to change their position regularly. Examination of the recording of repositioning evidenced these were well completed.

Management of wound care was examined. Review of one identified patient's care records confirmed that wound care was managed in keeping with best practice guidance.

Falls in the home were monitored monthly to enable the manager to identify if any patterns were emerging which in turn could assist the manager in taking actions to prevent further falls from occurring. There was a system in place to ensure that accidents and incidents were notified to patients' next of kin, their care manager and to RQIA, as required.

Review of the management falls evidenced appropriate actions were taken following the fall in keeping with best practice guidance. Review of one identified patient's care records evidenced that clinical and neurological observations had not been consistently completed following a recent fall. It was pleasing to note that this had been identified by the manager through their audit systems and the deficit addressed with the staff concerned.

At times, some patients may be required to use equipment that can be considered to be restrictive, for example, bed rails. Review of patients' records and discussion with the manager and staff confirmed that the correct procedures were followed if restrictive equipment was used. It was good to note that, where possible, patients were actively involved in the consultation process associated with the use of restrictive interventions and their informed consent was obtained.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Lunch was a pleasant and unhurried experience for the patients. The food served was attractively presented and smelled appetising and portions were generous. A variety of drinks were served with the meal. Patients may need support with meals ranging from simple encouragement to full assistance from staff. Staff attended to patients' dining needs in a caring and compassionate manner while maintaining written records of what patients had to eat and drink, as necessary. Patients spoke positively in relation to the quality of the meals provided.

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 were in place to direct staff. Staff told us how they were made aware of patients' nutritional needs to ensure that patients received the right consistency of food and fluids.

Patients' needs were assessed at the time of their admission to the home. Following this initial assessment, care plans should be developed to direct staff on how to meet patients' needs and included any advice or recommendations made by other healthcare professionals. Review of one identified patient's care records evidenced that care plans had been developed within a timely manner to accurately reflect their assessed needs.

Patients' individual likes and preferences were reflected throughout the care records. Care plans were detailed and contained specific information on each patient's care needs and what or who was important to them.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from and consultations with any healthcare professional was also recorded. Some of the daily records reviewed were seen to contain repetitive statements to evaluate patient care. The manager agreed to monitor records of daily evaluation to ensure these entries are more person centred.

5.2.3 Management of the Environment and Infection Prevention and Control

Examination of the home's environment evidenced the home was warm, clean and comfortable. Patients' bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, clean and tidy.

Fire safety measures were in place to ensure that patients, staff and visitors to the home were safe. Staff members were aware of their training in these areas and how to respond to any concerns or risks. A fire risk assessment had been completed on 15 November 2021. All actions identified by the assessor had been addressed by the manager.

The manager said that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. The home was participating in the regional testing arrangements for patients, staff and care partners and any outbreak of infection was reported to the Public Health Authority (PHA). All visitors to the home had a temperature check when they arrived. They were also required to wear personal protective equipment (PPE).

There were laminated posters displayed throughout the home to remind staff of good hand washing procedures and the correct method for applying and removing of PPE.

There was an adequate supply of PPE and hand sanitisers were always readily available throughout the home.

Discussion with staff confirmed that training on IPC measures and the use of PPE had been provided. Most staff members were observed to carry out hand hygiene at appropriate times and to use PPE correctly. A small number of deficits in individual staff practice were discussed with the manager who agreed to address this through supervision.

5.2.4 Quality of Life for Patients

Discussion with patients confirmed that they were able to choose how they spent their day. Some patients told us they liked the privacy of their bedrooms, but would enjoy going to the dining room or a lounge for meals if they did not have to isolate due to Covid-19 restrictions.

Patients were observed enjoying listening to music, reading newspapers/magazines and watching TV, while others enjoyed a visit from relatives. One patient said they enjoyed doing crosswords while another said they loved to my musical instruments. One relative spoke of how much their mother enjoys the activities delivered in the home.

There was evidence that some planned activities were being delivered for patients within the home. An activity planner displayed in the home confirmed varied activities were delivered which included one to one activities, a treat trolley, games, music and arts and crafts. Staff said the activity co-ordinator did a variety of one to one and group activities to ensure all patients had some activity engagement. Review of care records confirmed some patients did not have an individual activity assessment with a supporting care plan. This was discussed with the manager who agreed to review care planning for activities to ensure there is consistent oversight from registered nursing staff.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff assisted patients to make phone or video calls. Visiting and care partner arrangements were in place with positive benefits to the physical and mental wellbeing of patients.

5.2.5 Management and Governance Arrangements

Staff members were aware of who the person in charge of the home was, their own role in the home and how to raise any concerns or worries about patients, care practices or the environment.

There has been a change in the management of the home since the last inspection. Mrs Louisa Semple has been the manager since 18 October 2021. RQIA were notified appropriately.

There was evidence that a system of auditing was in place to monitor the quality of care and other services provided to patients. The manager or delegated staff members completed regular audits to quality assure care delivery and service provision within the home. The quality of the audits was generally good.

Review of records confirmed that systems were in place for staff appraisal and supervision.

There was a system in place to manage complaints. There was evidence that the manager ensured that complaints were managed correctly and that good records were maintained. The manager told us that complaints were seen as an opportunity for the team to learn and improve. Patients said that they knew who to approach if they had a complaint and had confidence that any complaint would be managed well.

Staff commented positively about the manager and the management team and described them as supportive, approachable and always available for guidance. Discussion with the manager and staff confirmed that there were good working relationships between staff and management.

A review of the records of accidents and incidents which had occurred in the home found that these were well managed correctly and reported appropriately.

The home was visited each month by a representative of the registered provider to consult with patients, their relatives and staff and to examine all areas of the running of the home. The reports of these visits were completed in detail. These are available for review by patients, their representatives, the Trust and RQIA.

6.0 Quality Improvement Plan/Areas for Improvement

This inspection resulted in no areas for improvement being identified. Findings of the inspection were discussed with Mrs Louisa Semple, manager**,** as part of the inspection process and can be found in the main body of the report.

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