The Regulation and Quality Improvement Authority

Inspection Report

06 May 2021

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/Registered Provider: Four Seasons Health Care **Responsible Individual:** Mrs Natasha Southall	**Registered Manager:** Mrs Claire Wilkinson - Not registered
Person in charge at the time of inspection: Mrs Claire Wilkinson	**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) 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:** 35
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 06 May 2021 at 10.00 am by the care inspector.

The inspection sought 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 environmental cleaning, teamwork and delivery of compassionate care.

Areas requiring improvement were identified in relation to wound management, menu choice and planning of patient care.

Patients spoke positively about living in the home. Patients unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff. Comments received from patients, relatives and staff are included in the main body of this report.

RQIA were assured that the delivery of care and service provided in Edenvale Care Home was safe, effective, compassionate and that the home was well led.

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, their relatives or visitors and staff were asked for their opinion on the quality of the care and their experience of living, visiting 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 Person in Charge at the conclusion of the inspection.

4.0 What people told us about the service

During the inspection we spoke with 14 patients, five staff and one relative. Six questionnaires were returned and we received no feedback from the staff online survey. Patients spoke highly on the care that they received and on 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. Staff acknowledged the difficulties of working through the COVID – 19 pandemic but all staff agreed that Edenvale Care Home was a good place to work. Staff 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?

The last inspection to Edenvale Care Home was undertaken 10 November 2020 by a pharmacy inspector; no areas for improvement were identified.

5.2 Inspection findings

5.2.1 How does this service ensure that staffing is safe?

Safe staffing begins at the point of recruitment. There was a robust system in place to ensure staff were recruited correctly to protect patients as far as possible. All staff were provided with a comprehensive induction programme to prepare them for working with the patients, this also included agency or temporary staff.

There were systems in place to ensure staff were trained and supported to do their job. Staff consulted with confirmed they received regular training in a range of topics such as moving and handling, infection prevention and control (IPC) and safeguarding of vulnerable adults. The majority of training during the COVID-19 pandemic had been completed electronically. A new electronic training system has been recently introduced. The manager confirmed Deprivation of Liberty Safeguards (DOLS) was included in the suite of training and this would be completed by all staff.

Staff said there was good team work and that they felt well supported in their role. They expressed no concerns with the staffing levels and the level of communication between staff and management.

The staff duty rota accurately reflected all of the staff working in the home on a daily basis. The duty rota identified the person in charge when the Manager was not on duty. The Manager told us that the number of staff on duty was regularly reviewed to ensure the needs of the patients were met.

Staff told us that the patients' needs and wishes were very important to them. It was observed that staff responded to requests for assistance promptly in a caring and compassionate manner.

Patients said staff were always available and responded promptly to call bells. One patient described the care as “first class” and referred to the staff as “wonderful”. Another patient told us the care was “excellent”.

One patient’s relative spoke very highly of the care their relative received. They said, “the Manager is terrific and every member of staff is brilliant”.

5.2.2 How does this service ensure patients feel safe from harm and are safe in the home?

Each service is required to have a person, known as the adult safeguarding champion, who has responsibility for implementing the regional protocol and the home’s safeguarding policy. The Regional Manager was identified as the appointed safeguarding champion for the home.

Review of staff training records confirmed that all staff were required to completed adult safeguarding training on an annual yearly basis. Staff told us they were confident about reporting concerns about patients’ safety and poor practice.

It was noted that patients and their relatives were provided with written information on how to raise a concern or complaint about care or any service they received in the home. Patients told us that they would have no issues in raising concerns with the home’s staff. Complaints were monitored monthly in the home.

At times some patients may be required to use equipment that can be considered to be restrictive, such as bed rails or alarm mats. Review of patient records and discussion with the Manager and staff confirmed that the correct procedures were followed if restrictive equipment was required. It was good to note that patients who had capacity were actively involved in the consultation process and could give informed consent. This was good practice. The Manager confirmed they would be prioritising deprivation of liberty training for all staff following the inspection.

Staff 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 were skilled in communicating with patients; they were respectful, understanding and sensitive to their needs. This was evident when staff were assisting patients with mobilising and at mealtimes.

5.2.3 Is the home’s environment well managed to ensure patients are comfortable and safe?

Examination of the home’s environment included reviewing a sample of bedrooms, storage spaces, the kitchen, and communal areas such as lounges and bathrooms. There was evidence that the environment was well maintained. It was noted that the home had been recently painted and new vinyl flooring had been fitted downstairs. The Manager confirmed they were choosing new soft furnishings and had a refurbishment plan for other areas of the home.

Patients’ bedrooms were personalised with items important to the patient. Bedrooms and communal areas were well decorated, suitably furnished, clean and tidy. Patients could choose where to sit or where to take their meals and staff were observed supporting patients to make these choices. Most dining rooms were arranged in such a way that patients could safely

socially distance, although one dining room was not. This was discussed with staff who configured the room to accommodate socially distanced dining.

Patients spoke positively about the home and said it was clean and tidy.

Fire safety measures were in place and well managed to ensure patients, staff and visitors to the home were safe. Staff were aware of their training in these areas and how to respond to any concerns or risks. Corridors and fire exits were clear of clutter and obstruction. A fire risk assessment had been completed in September 2020; any recommendations had been addressed. Review of the emergency evacuation file confirmed it was reflective of the current occupancy in the home.

5.2.4 How does this service manage the risk of infection?

The Manager told us that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases. For example, the home participated 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 and a health declaration completed when they arrived at the home. They were also required to wear personal protective equipment (PPE) such as aprons, masks and/or gloves.

Review of records, observation of practice and discussion with staff confirmed that effective training on infection prevention and control (IPC) measures and the use of PPE had been provided.

Most staff were observed to carry out hand hygiene at appropriate times and to use PPE in accordance with the regional guidance. Staff use of PPE and hand hygiene was regularly monitored by the Manager and records were kept. However, one staff member was observed using PPE inappropriately; other staff were observed to be using vinyl gloves which are not recommended for use if there is a risk of contact with blood or bodily fluids. This was discussed with the Manager who agreed to address the staff members practice through supervision and ensure the use of vinyl gloves is reviewed in keeping with best practice guidance.

Visiting arrangements were managed in line with Department of Health (DoH) and IPC guidance. The Manager confirmed the visiting policy was being reviewed in keeping with current DoH guidance.

5.2.5 What arrangements are in place to ensure patients receive the right care at the right time? This includes how staff communicate patients' care needs, ensure patients' rights to privacy and dignity; manage skin care, falls and nutrition.

Staff met at the beginning of each shift to discuss any changes in the needs of the patients. The majority of patient care records maintained accurately reflected the needs of the patients. This is discussed further in 5.2.6. Staff were knowledgeable of individual patients' needs, their daily routine wishes and preferences.

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. This was good practice.

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. Patients who required this care or who had wounds had this clearly record in their care records. There was evidence that nursing staff had consulted with the Tissue Viability Specialist Nurse (TVN) or Podiatrist and were following any recommendations they had made.

Review of one identified patients care records confirmed wound assessments and evaluations were not always completed after their wound was dressed. Review of care records for another identified patient evidenced a previous plan of care had not been discontinued and it was unclear which plan of care was to be followed. An area for improvement was identified.

Examination of records and discussion with the Manager and staff confirmed that the risk of falling and falls were well managed. For example, when a patient has had a fall it is good practice to complete a review to determine if anything more could have been done to prevent the fall. This is known as a post fall review. Such reviews were being completed. Review of care records for one identified patients fall evidenced that appropriate actions were taken following the fall in keeping with best practice guidance. However, daily records did not consistently comment on the patients clinical and neurological observations that were taken over a 24 hour period. This was discussed with the Manager who agreed to address this through clinical supervision with staff as required.

There was a system in place to ensure accidents and incidents were notified, if required, to patients' next of kin, their care manager and to RQIA.

Good nutrition and a positive dining experience are important to the health and social wellbeing of patients. Patients may need a range of support with meals; this could include simple encouragement through to full assistance from staff. There was evidence that patients' needs in relation to nutrition and the dining experience were being met. For example, during lunch staff wore the appropriate aprons when serving or assisting patients with meals and clothing protectors were used for patients as required.

Lunch was observed to be supervised by staff and was a pleasant and unhurried experience for the patients. There was choice of meals offered, the food was attractively presented and smelled appetising, and portions were generous. There was a variety of drinks available. Plastic tumblers were used at mealtimes for serving drinks to patients who did not eat in the dining room; glassware was available in the dining room. The Manager agreed to review the use of plastic tumblers to ensure patients who prefer to use glass are facilitated.

Staff confirmed the menu had been recently revised by their parent company in England and patients had not been involved in discussions prior to the changes being implemented. Review of the menu evidenced it had not been developed to reflect regional variances between meals traditionally eaten in England compared to Northern Ireland. An area for improvement was identified to ensure patients are involved in the design of planned menus.

There was evidence that patients' weights were checked at least monthly to monitor weight loss or gain. If required, records were kept of what patients had to eat and drink daily.

Patients told us they enjoyed the food in the home.

5.2.6 What systems are in place to ensure care records reflect the changing care needs of patients?

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. We saw evidence of this in most of the care records examined. However, review of one identified patient's care records evidenced care plans had not been developed in a timely manner, to guide the staff in the delivery of daily care needs. Care plans had not been developed within five days of admission to the home to accurately reflect the assessed needs of the patient. An area for improvement was identified.

Care records were generally well maintained, regularly reviewed and updated to ensure they continued to meet the patients' needs. Patients, where possible, were involved in planning their own care and the details of care plans were shared with patients' relatives, if this was appropriate.

Daily records were kept of how each patient spent their day and the care and support provided by staff. The outcome of visits from any healthcare professional was recorded.

5.2.7 How does the service support patients to have meaning and purpose to their day?

Discussion with patients confirmed that they were able to choose how they spent their day. For example, patients could have a lie in or stay up late to watch TV. Patients confirmed that they could go out for a walk when they wanted, remain in their bedroom or go to a communal room when they requested. One patient had satellite television in their bedroom which they enjoyed.

During the inspection patients were observed enjoying listening to music and watching TV. A weekly schedule of activities was available for review. Patients and staff told us activities were conducted with groups of patients or on a one to one basis. Patients commented positively on the activity provision in the home. Patients' needs were met through a range of individual and group activities, such as tea parties, bingo, sensory activities and religious services.

One to one activities were tailored to meet individual preferences. Review of the duty rota evidenced no staff had been allocated to lead on activities on the day of the inspection. In addition, activity provision was not regularly commented on in patient's daily progress notes. The manager confirmed they planned to review activity provision to address these deficits and will ensure all patients have an individual activity assessment with accompanying care plan. These should be reviewed by registered nursing staff as required.

Staff recognised the importance of maintaining good communication with families, especially whilst visiting was disrupted due to the COVID-19 pandemic. Staff told us they 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. The Manager confirmed a visiting champion was on duty every day to support patients with meaningful and safe visits.

5.2.8 What management systems are in place to monitor the quality of care and services provided by the home and to drive improvement?

Staff 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 Claire Wilkinson has been the Manager in this home since December 2020. RQIA were notified appropriately and an application has been received by RQIA to register her as Registered Manager.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to patients. The Manager or members of the team completed regular audit of accidents/incidents, complaints, wounds, care records, restraint, infection control and staff registrations.

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 to for the team to learn and improve. Patients and their relatives 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 described her as supportive, approachable and always available for guidance. Staff said “Claire goes out of her way to support us” and “the Manager is very approachable”.

A record of compliments received about the home was kept and shared with the staff team, this is good practice. Compliments were received from patients, patients’ relatives/representatives, current staff members and staff members who had left the home.

A review of the records of accidents and incidents which had occurred in the home found that these were 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; where action plans for improvement were put in place, these were followed up to ensure that the actions were correctly addressed. These are available for review by patients, their representatives, the Trust and RQIA.

6.0 Conclusion

As a result of this inspection three areas for improvement were identified in respect of wound management, menu choice and planning of patient care. Details can be found in the Quality Improvement Plan included.

Evidence of good practice was found in relation to environmental cleaning, teamwork and delivery of compassionate care. There were safe systems in place to ensure staff were recruited and trained properly; and that patient’s needs were met by the number and skill of the staff on duty. Systems were in place to ensure patients’ safety. Patients were complimentary in relation to the environment and with the cleanliness in the home. The risk of infection was monitored during IPC audits. Patients’ care records had been generally well maintained; any improvements required are detailed in the Quality Improvement Plan.

Patients chose how to spend their day in the home and in which area to spend it. They could engage in the arranged activities in the home or with their own preferred activity such as reading or watching television. The Manager agreed to review allocation of activities in the absence of the patient activity lead and plans to review activity care plans. Systems were in place to monitor the quality of services and drive improvements. Complaints had been managed well and compliments shared with staff. Accidents had been managed appropriately and there was good communication between the homes management and staff.

Based on the inspection findings and discussions held we are satisfied that Edenvale Care Home is providing safe and effective care in a caring and compassionate manner; and that the service is well led by the Manager.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with wound management, menu choice and planning of patient care.

	Regulations	Standards
Total number of Areas for Improvement	0	3

Areas for improvement and details of the Quality Improvement Plan were discussed with Mrs Claire Wilkinson, Manager, as part of the inspection process. The timescales for completion commence from the date of inspection.

Quality Improvement Plan

Action required to ensure compliance with the Care Standards for Nursing Homes (April 2015)	
Area for improvement 1 **Ref**: Standard 21.1 **Stated:** First time **To be completed by:** Immediate action required	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. Ref: 5.2.5
	Response by registered person detailing the actions taken: Individual support meetings held with SNs/CHAP to ensure understanding and compliance of correct process. Wound monitoring and documentation diarised to ensure completion by all staff including flexi/agency. Home Manager to regularly monitor wound progression and completion of wound related documentation. SN Wound competencies in date and renewed annually.
Area for improvement 2 **Ref**: Standard 12 **Stated:** First time **To be completed by:** Immediate action required	The registered person shall ensure patients are involved in planning the menu to ensure their preferences are considered. Ref: 5.2.5
	Response by registered person detailing the actions taken: Menu created following completion of food questionnaires. Home continues to provide the resident with alternatives and adapt choice to reflect regional dishes when requested/needed. Menu and meals discussed with residents during residents meetings and requests actioned.

Area for improvement 3 **Ref**: Standard 4.1 **Stated:** First time **To be completed by:** Immediate action required	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. Ref: 5.2.6
	Response by registered person detailing the actions taken: Individual meetings held with staff to ensure full understanding and compliance of correct process. Supervisions completed for written documentation, care planning and evaluation. Actions diarised on admission to ensure completion by all staff nurses. Admissions list added to all new admission carefiles for completion. Home Manager to have regular oversight of all new admission documentation - carefile audit to be completed 5-7 days after admission to identify any deficits and implement prompt actions to rectify.

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