Inspection Report

29 July 2024

Edgewater Lodge

Type of service: Residential
Address: Seaview Suite, 4 Sunnydale Avenue, Donaghadee, BT21 0LE
Telephone number: 028 9188 8044

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: Electus Healthcare 1 Limited **Responsible Individual:** Mr Ed Coyle	**Registered Manager:** Mr Paul Williamson – not registered
Person in charge at the time of inspection: Mr Paul Williamson	**Number of registered places:** 17
Categories of care: Residential Care (RC) DE – Dementia.	**Number of residents accommodated in the residential care home on the day of this inspection:** 17
Brief description of the accommodation/how the service operates: This home is a registered residential care home which provides health and social care for up to 17 residents. Residents' bedrooms, the lounges and dining room are located over one level and residents have access to an enclosed garden area. The home is located within a nursing home and the same manager manages both services.	

2.0 Inspection summary

An unannounced inspection took place on 29 July 2024, from 9.10 am to 7.30 pm by two care inspectors.

The inspection assessed progress with all areas for improvement identified in the home 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.

Nine new areas requiring improvement were identified. Please refer to the Quality Improvement Plan (QIP) in section 7.0 for details.

Residents said that living in the home was a good experience. Residents unable to voice their opinions were observed to be relaxed and comfortable in their surroundings and in their interactions with staff.

RQIA were assured that the delivery of care and service provided in Edgewater Lodge was safe, effective, compassionate and that the home was well led. Addressing the areas for improvement will further enhance the quality of care and services in Edgewater Lodge.

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

To prepare for this inspection we reviewed information held by RQIA about this home. This included the previous areas for improvement issued, registration information, and any other written or verbal information received from residents, relatives, staff or the Commissioning Trust.

Throughout the inspection RQIA will seek to speak with residents, their relatives or visitors and staff for their opinion on the quality of the care and their experience of living, visiting or working in this home.

Questionnaires were provided to give residents 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 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.

The findings of the inspection were discussed with the management team at the conclusion of the inspection.

4.0 What people told us about the service

Residents commented positively regarding the home and said they felt they were well looked after. A resident told us of how, "The staff are attentive, the food is good and there is plenty to do." Another resident spoke of how, "The staff are there if I need them, I have no complaints."

A relative spoke of how," The care in the home was excellent. The staff are attentive and communication is good."

Another relative spoke of how there was," A consistent core of staff. The standard of care is good; it is group living at its best. They always go the extra mile"

Staff told us they were happy working in the home, that there was enough staff on duty and felt supported by the manager and the training provided.

No additional feedback was provided from residents, relatives or staff following the inspection.

A record of compliments received about the home was kept and shared with the staff team, this is good practice.

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 7 September 2023		
Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022) (Version 1:2)		**Validation of compliance**
Area for Improvement 1 **Ref:** Standard 19 **Stated:** First time	The registered person shall ensure that reasons for leaving previous employment are explored and recorded prior to making an offer of employment.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for improvement 2 **Ref:** Standard 8.2 **Stated:** First time	The registered person shall ensure that all relevant care record documentation is completed and/or updated in the event of a fall.	**Met**
	Action taken as confirmed during the inspection: There was evidence that this area for improvement was met.	
Area for Improvement 3 **Ref:** Standard 10 **Stated:** First time	The registered person shall ensure that care records regarding management of behaviours that challenge are detailed, reflect identified triggers and behaviours and provide guidance on the actions required to promote a consistent approach. Daily care records should reflect any challenges experienced and how these were managed.	**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

Safe staffing begins at the point of recruitment. There was evidence that a robust system was in place to ensure staff were recruited correctly to protect residents.

There was a system in place to ensure staff were registered with the Northern Ireland Social Care Council (NISCC).

Review of staff training records confirmed that all staff were not up to date with mandatory training such as Control of Substances Hazardous to Health (COSHH), behaviours that challenge, Depravation of Liberty Safeguards(DoLS) and fire safety training. An area for improvement was identified.

Review of staff meeting minutes confirmed that staff meetings were not held on at least a quarterly basis. There were no separate records for the residential home as joint staff meetings were held with the nursing home. An area for improvement was identified.

Staff said there was good team work and that they felt well supported in their role, were satisfied with the staffing levels and the level of communication between staff and management.

The duty rota identified the person in charge when the manager was not on duty. The duty rota did not include the manager's hours. This was discussed with the manager for his action.

Staff told us that there was enough staff on duty to meet the needs of the residents.

5.2.2 Care Delivery and Record Keeping

Staff were observed to be prompt in recognising residents' needs and any early signs of distress or illness, including those residents who had difficulty in making their wishes or feelings known. Staff were skilled in communicating with residents; they were respectful, understanding and sensitive to residents' needs.

Staff met at the beginning of each shift to discuss any changes in the needs of the residents. In addition, resident care records were maintained which accurately reflected the needs of the residents. Staff were knowledgeable of individual residents' needs, their daily routine wishes and preferences.

It was observed that staff respected residents' privacy by their actions such as knocking on doors before entering, discussing residents' care in a confidential manner, and by offering personal care to residents discreetly.

Examination of records and discussion with the manager confirmed that the risk of falling and falls were well managed.

Good nutrition and a positive dining experience are important to the health and social wellbeing of residents. Residents may need a range of support with meals; this may include simple encouragement through to full assistance from staff.

The daily menu was on display in the dining room, but not in a dementia friendly format. An area for improvement was identified.

The dining experience was an opportunity of residents to socialise, music was playing, and the atmosphere was calm, relaxed and unhurried. It was observed that residents were enjoying their meal and their dining experience. Staff had made an effort to ensure residents were comfortable, had a pleasant experience and had a meal that they enjoyed.

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. lunch was a pleasant and unhurried experience for the residents.

Plastic glasses, cups and jugs provided to patients were visibly stained and worn. This was discussed with the manager and an area for improvement was identified.

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

Residents' needs were assessed at the time of their admission to the home. Following this initial assessment care plans were developed to direct staff on how to meet residents' needs; and included any advice or recommendations made by other healthcare professionals. Residents care records were held confidentially.

The daily evaluation of care was generic in nature and not personalised. Ways of enhancing the recording was discussed the manager. The daily evaluations also contained repetitive statements. This was discussed with the manager for his action and will be reviewed at a subsequent inspection. The outcome of visits from any healthcare professional was recorded.

Review of care plans highlighted that some care plans did not reflect the resident's needs. Care plans reviewed did not include reference to DOL safeguards that were in place, or the provision of commodes in bedrooms. Another care plan did not include any reference to the impact of a sensory impairment on the provision of the residents' care, and their activity provision. Another care plan did not reference the use of an oxygen concentrator. These issues were discussed with the manager, and an area for improvement was identified. Residents, where possible, were involved in planning their own care and the details of care plans were shared with residents' relatives, if this was appropriate.

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

Each resident had an annual review of their care, arranged by their care manager or Trust representative.

This review should include the resident, the home staff and the resident's next of kin, if appropriate. A record of the meeting, including any actions required, was provided to the home.

5.2.3 Management of the Environment and Infection Prevention and Control

Observation of the home's environment evidenced that the home was tidy and well maintained. There was a malodour evident in one bedroom. An area for improvement was identified.

Residents' bedrooms were personalised with items important to the resident. Bedrooms and communal areas were well decorated, suitably furnished, and comfortable. Residents could choose where to sit or where to take their meals and staff were observed supporting residents to make these choices.

Vinyl gloves were available in PPE dispensing units and were being used by domestic staff. This type of glove is not suitable for use in personal care or cleaning within healthcare setting as indicated by the Regional IPC Guidance. This was discussed with the manager and an area for improvement was identified.

Fire safety measures were in place and well managed to ensure residents, 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.

An oxygen cylinder in a resident's bedroom was not secured correctly. This was discussed with the manager and an area for improvement was identified.

A number of residents' bedrooms did not have a call bell lead available. There was no clear alternative system in place to ensure residents could summon assistance if required. This was discussed with the manager and an area for improvement was identified.

There was evidence that systems and processes were in place to ensure the management of risks associated with COVID-19 infection and other infectious diseases

5.2.4 Quality of Life for Residents

Discussion with residents confirmed that they were able to choose how they spent their day. For example, residents could have a lie in or stay up late to watch TV.

It was observed that staff offered choices to residents throughout the day which included preferences for getting up and going to bed, what clothes they wanted to wear, food and drink options, and where and how they wished to spend their time.

Residents' needs were met through a range of individual and group activities, such as arts and crafts, musical activities, movies and arts and crafts.

5.2.5 Management and Governance Arrangements

There has been no change in the management of the home since the last inspection. Mr Paul Williamson has been the manager in the home since 3 October 2022. However, after the inspection RQIA were notified by the Responsible Individual that the deputy manager had been appointed as acting manager until further notice.

There was evidence that a robust system of auditing was in place to monitor the quality of care and other services provided to residents. There was evidence of auditing across various aspects of care and services provided by 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 manager was identified as the appointed safeguarding champion for the home. It was established that good systems and processes were in place to manage the safeguarding and protection of vulnerable adults.

The annual safeguarding position report for the Residential Home was being combined with the report from the Nursing Home. There needs to be a separate report for each home. This was discussed with the manager and will be reviewed at a subsequent inspection.

Residents and relatives spoken with said that they knew how to report any concerns and said they were confident that the manager would address these. Review of the home's record of complaints confirmed that these were well managed and used as a learning opportunity to improve practices and the quality of services provided by the home. This is good practice.

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 residents, care practices or the environment.

It was established that the manager had a system in place to monitor accidents and incident that happened in the home. Accidents and incidents were notified, if required, to residents' next of kin, their care manager and to RQIA. A review of the records of accidents and incidents which had occurred in the home found that these were managed correctly and reported appropriately.

There was a system in place to manage complaints. Residents 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.

The home was visited each month by a representative of the registered provider to consult with residents, 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. It was discussed with the management team the need for these reports to be signed by the manager. These reports are available for review by residents, their representatives, the Trust and RQIA.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified were action is required to ensure compliance with **The Residential Care Homes Regulations (Northern Ireland) 2005 and the Residential Care Homes' Minimum Standards (December 2022) (Version 1:2)**

	Regulations	Standards
Total number of Areas for Improvement	2	7

Areas for improvement and details of the Quality Improvement Plan were discussed with Mr Paul Williamson, 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 Residential Care Homes Regulations (Northern Ireland) 2005	
Area for improvement 1 **Ref:** Regulation 13 (8)(a) **Stated:** First time **To be completed by:** From the date of inspection 29 July 2024.	The registered person shall make suitable arrangement to ensure that the home is conducted in a manner which does not potentially impact on the well-being and dignity of residents. This is stated in relation to the provision of suitable jugs and cups used by residents Ref: 5.2.2
	Response by registered person detailing the actions taken: New cups, jugs, Glasses and crockery have been purchased and all damaged items have been removed. This will be monitored monthly to ensure supplies are maintained.
Area for improvement 2 **Ref**: Regulation 13 (7) **Stated:** First time **To be completed by:** From the date of inspection 29 July 2024.	The registered person shall ensure staff have access to appropriate personal protective equipment and are trained in how and when to use it.
	Response by registered person detailing the actions taken: 90% of staff have now completed IPC online training and a further face to face session has been arranged with the IPC lead form the South Eastern Trust. All staff have now also completed an IPC competency and supervision on the donning and doffing of PPE.
Action required to ensure compliance with the Residential Care Homes Minimum Standards (December 2022) (Version 1:2)	
Area for improvement 1 **Ref:** Standard 23.3 **Stated:** First time **To be completed by:** 29 October 2024.	The registered person shall ensure that mandatory training requirements are met. This is stated in relation to Control of Substances Hazardous to Health (COSHH), behaviours that challenge, Depravation of Liberty Safeguards(DoLS) and fire safety training Ref: 5.2.1

	Response by registered person detailing the actions taken: 88% Of staff have now completed their online COSHH training, and face to face COSHH training sessions have been held and further sessions have been scheduled. All staff have also completed a COSHH competency assessment and COSHH supervision. Compliance is monitored on a daily walk round and also the completion of the Regulation 23 visit.
Area for improvement 2 **Ref:** Standard 25.8 **Stated:** First time **To be completed by:** 29 October 2024	The registered person shall ensure that staff meetings take place on a regular basis, at a minimum quarterly. Separate staff meeting minutes should be retained for the residential home. Ref: 5.2.1
	Response by registered person detailing the actions taken: A staff meeting schedule has been put in place and is on display in the units to infirm staff of the dates of meetings. The nursing home and residential home going forward will have separate meetings. A sign in sheet is used and minutes are recorded. Any actions required will be shared and a copy of the minutes will be made available to all staff on request.
Area for improvement 3 **Ref:** Standard 12.4 **Stated:** First time **To be completed by:** From the date of inspection 29 July 2024.	The registered person shall ensure that a daily menu is on display in a suitable format and in an appropriate location, showing residents and their representatives what is available each mealtime. Ref: 5.2.2
	Response by registered person detailing the actions taken: Pictorial menus are now in place and available for residents to use. The daily menu is displayed in the dining room for all residents to view. A choice sheet is also available for residents to assist them with menu choices.
Area for improvement 4 **Ref:** Standard 6 **Stated:** First time **To be completed by:** From the date of inspection 29 July 2024	The registered person shall ensure that each resident has an individual and up to date care plan. This is stated in relation to: • Reference to DOL safeguards • Provision of commodes in bedrooms • Reference to a sensory impairment on the provision of an identified residents care, and the resident's activity provision and daily routine. • The use of an Oxygen concentrator Ref: 5.2.2

	Response by registered person detailing the actions taken: All care plans have been reviewed and updated in relation ti the care plan issues raised. The required care plans are now in place.
Area for improvement 5 **Ref:** Standard 27.1 **Stated:** First time **To be completed by:** 29 October 2024.	The registered person shall ensure that the malodour in the identified bedroom is addressed. Ref: 5.2.3
	Response by registered person detailing the actions taken: The mattress has been changed and the room flooring has been deep cleaned. This is monitored daily to ensure the malodour is kept at bay.
Area for improvement 6 **Ref:** Standard 32 **Stated:** First time **To be completed by:** From the date of inspection 29 July 2024.	The registered person shall ensure that oxygen cylinders are safely and securely stored Ref: 5.2.3
	Response by registered person detailing the actions taken: The additional oxygen cylinder has now been removed and the oxygen cylinder held in the treatment room has now been secured to the wall.
Area for improvement 7 **Ref:** Standard 6.2 **Stated:** First time **To be completed by:** From the date of inspection 29 July 2024.	The registered person shall ensure that resident call bells are provided in every room used by residents when safe to do so. For residents who cannot safely use a call bell, their care plans should detail the alternative measures in place to ensure their safety and comfort. Ref: 5.2.3
	Response by registered person detailing the actions taken: A full audit has been completed of all call bells. Those who do not have a call bell now have a care plan to reflect the alternative measures and to advise of the reason as to why they do not have a call bell in place.

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