Akari Care Limited

Edgeley House Care Home

Inspection report

Edgeley Road
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Inadequate
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

This inspection was unannounced and took place on 16 and 17 December 2015.

Edgeley House Care Home provides nursing and personal care for up to 60 older people and people living with dementia. On the days of our inspection 38 people were living there.

The home has not had a registered manager in post since October 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our previous inspection in May 2014, the provider was in breach of the regulation relating to the suitability of the premises. We asked the provider to take action to make improvements to ensure the safety of the premises. The provider sent us an action plan July 2014, telling us what they would do to make improvements. We found at this inspection the provider had taken the necessary measures to ensure the premises were safe and suitable to meet people's needs.

Summary of findings

Staff were not always nearby to support people when needed and this placed them at risk. Although people felt safe living in the home and staff knew how to protect them from potential harm the practices we saw did not always demonstrate this. Staff told us they had access to risk assessments that told them how to support people safely and equipment required to assist them. Accidents and incidents were recorded and action taken to avoid them happening again. People's medicines were managed safely and they received them when needed. Medicines were stored appropriately and records were maintained to show when medicines had been given to people.

We saw that staff were not always sympathetic to people's needs and they were not always supported. Practices within the home did not ensure everyone was involved in their care planning so they received a service the way they liked. Staff did not respect people's right to privacy and dignity.

People were not always involved in the assessment of their needs and the provider had not explored people's interests and hobbies. There was limited stimulation provided and people told us they were bored. People were unaware of the provider's complaint procedure but said they would share their concerns with staff. We found that complaints were listened to and managed appropriately.

The provider did not have a registered manager and people were unaware of who was running the home. There was no clear leadership and staff felt unsupported. We found that the provider's quality assurance monitoring audit systems were not robust to ensure people received a safe and effective service.

Staff had access to training to ensure they had the skills to care for people. Staff did not receive regular supervision and they felt unsupported by the management team. We found that not all staff were aware of the principles of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguard (DoLS) and this placed people at risk of their human rights not being protected.

People had a choice of meals but we found that where people required support with their meals this was not always provided. People had access to other healthcare services to ensure their healthcare needs were met.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures.'

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People felt safe living in the home but staff were not always nearby to support them. People received their medicines when needed and staff had access to risk assessments that told them how to support people safely.

Requires improvement

Is the service effective?
The service was not consistently effective.

People were cared for by staff who had received training but did not receive regular supervision to support them in their role. People were not always encouraged to make decisions about their care. They had a choice of meals but they were not always supported with their meals when needed. People had access to healthcare services when required.

Requires improvement

Is the service caring?
The service was not caring.

People's care and support needs were not always met because staff did not recognise their right to privacy and dignity. People were not always involved in their care planning to ensure they received care the way they liked.

Inadequate

Is the service responsive?
The service was not always responsive.

People were not always involved in the assessment of their needs and were not supported to pursue their hobbies and interests. People were unaware of the provider's complaints procedure but were confident to share their concerns with staff.

Requires improvement

Is the service well-led?
The service was not well-led.

There was no clear leadership and quality assurance monitoring audits were not robust to identify the shortfalls we found. People were not involved in the running of the home and staff were not supported to provide an effective service.

Inadequate

Edgeley House Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 and 17 December 2015 and was unannounced. The inspection team comprised of two inspectors.

As part of our inspection we spoke with the local authority to share information they held about the home. We also looked at information we held about the provider to see if we had received any concerns or compliments about the home. We reviewed information of statutory notifications we had received from the provider. A statutory notification is information about important events which the provider is required to send us by law. We used this information to help us plan our inspection of the home.

During the inspection we spoke with seven people who used the service, two care staff, two nurses, the activity coordinator, two agency staff, four visitors and two regional managers. We looked at three care plans and risk assessments, medication administration records, accident reports and quality audits. We observed care practices and how staff interacted with people. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires improvement

Is the service safe?

Our findings

At our previous inspection in May 2014, the provider was in breach of the regulation relating to the suitability of the premises. The provider sent us an action plan to tell us what they would do to ensure the premises were suitable to meet people's needs. At this inspection we found that the provider had taken the appropriate measures to ensure the suitability of the premises.

Staff were not always available to support people who were unable to ask for assistance. For example, at lunch time there were no staff nearby to help people with their meal. We saw one person trying to eat their meal with a knife and their food fell in their lap. One person's meal was placed on their lap and they did not eat it. Staff were not available to support and encourage people to eat and drink. We heard another person calling for assistance; no staff came to help them. We pressed the nurse call button on their behalf. The person pointed to their feet and we saw that their slipper had fallen off. A member of the inspection team helped the person to put their slippers on because staff did not respond to their call for help or the nurse call alarm. After 45 minutes we saw a staff enter the room with the drinks trolley. We asked them why they had not responded to the nurse call alarm that was still activated and they told us they had been on their break and the other staff were updating care records.

We saw another person was anxious and distressed saying they wanted to leave the home. There were no staff nearby to reassure them. Later, during the inspection we were told the person had left the home without support and this had placed them at risk of harm. The person was found in the town and staff returned them to the home. The nurse in charge told us that the person would be supervised more closely until they settled. The lack of supervision and attention meant this person's needs were not met.

One staff member said there were not enough staff on duty to keep people safe and they don't get the attention needed. They said, "The staffing levels are diabolical." Another staff member said three people had sustained falls because there were not enough staff to keep them safe. Records showed that the majority of accidents related to falls but we were unable to determine whether this was due to staffing levels. Whilst there were no staff nearby one person entered the treatment room that had not been secured. They had access to prescribed medicines which placed them at risk of harm. We alerted the nurse in charge and the management team to this in order to keep the person safe

An agency worker said, "The home is very busy and understaffed." The regional manager acknowledged that on the day of the inspection there were not enough staff on duty and said this was due to an agency worker not turning up for duty. A staff member said this meant there were two staff to look after 24 people on a unit. The regional manager was confident sufficient staffing levels were provided but acknowledged that staff may not have been deployed effectively to meet people's care and support needs. The regional manager assured us that the deployment of staff would be reviewed.

This is a breach of regulation 18, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The regional manager said the provider's recruitment procedure ensured all new staff had the appropriate safety checks before they started work in the home and the staff we spoke with confirmed this.

The regional manager said when a person had an accident their care plan and risk assessment would be reviewed to tell staff what to do to reduce a reoccurrence. Care records showed that some people had been referred to a falls clinic to support them and staff in preventing further falls. We found that accidents and incidents were recorded and showed what action had been taken to avoid them happening again.

Requires improvement

Is the service safe?

People told us they felt safe living in the home. Staff said they would report poor care practices to the manager and were aware of other agencies they could share concerns with to protect people from further harm. Staff told us they had shared concerns with the regional manager about staffing levels but no action had been taken to resolve this and they did not share their concerns with any other agencies. The regional manager said that concerns relating to poor care practices or abuse were recorded and showed what action had been taken to reduce the risk of further harm. The regional manager was aware of when to share information with the local authority to safeguard people.

Staff told us they had access to risk assessments that told them how to support people in a safe manner. We saw that these assessments provided information about how to care for people safely. Risk assessments told staff about equipment the individual required to promote their independence and ensure their safety. Staff understood the risk associated with people's care and we saw them assisting people with the equipment identified in the risk assessment to ensure they were supported safely.

People told us that staff managed their medicines and they received them when required. Medicines were managed by trained nurses. Medicines were stored appropriately and records were maintained to show when medicines had been administered and disposed of. Nurses had access to written protocols that told them how to manage 'when required' medicines. These are medicines that were prescribed to be given only when needed. Controlled medicines were maintained and recorded in accordance with good practice.

Requires improvement

Is the service effective?

Our findings

Staff told us they had access to training that provided them with the skills to carry out their role but did not receive regular supervision. One staff member said, "I am unsure if I am doing my job properly because I don't receive supervision." We spoke with a member of staff who had been in post for one month. They told us they had not received supervision or training relating to their new role and responsibility and they felt unsupported.

The regional manager told us that new staff were provided with an induction and two staff members confirmed this. We found that the induction process was not robust to ensure staff knew how to do their job. One staff member said their induction consisted of reading care plans. They said the fire alarms had been activated and they were unaware of the evacuation procedure because this had not been covered during their induction. They said, "I felt like I had been thrown in the deep end." We spoke with an agency worker who told us they had not been provided with induction. They were unaware of essential information relating to people's care needs and the fire evacuation procedure and this placed them and people at risk.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005, and whether any conditions on authorisations to deprive a person of their liberty were being met. One person told us, "Staff always ask my permission before they do anything for me." The regional manager said people's consent was obtained where possible but when we spoke with staff they told us that people were not always involved in decisions about their care. We looked at one care record that showed the person had given their consent for the use of bedrails. Although the person was deemed to have capacity to make a decision a MCA assessment had been carried out. The regional manager was unable to tell us why the person's mental capacity had been assessed.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

We found that not all staff were aware of the principles of the Mental Capacity Act 2005. Where a Deprivation of Liberty Safeguard (DoLS) was in place not all the staff we spoke with were aware of this. We were told that one person had left the home without support but staff did not know if a DoLS was in place to deprive the person of their liberty to keep them safe. Therefore, people were at risk of not receiving the appropriate support and their human rights not being protected.

The people we spoke with said they had a choice of meals. A menuboard displayed in the dining area showed what meals were on offer. People said the meals were good. However, we saw that where people required support with their meal this was not always provided. We saw one person struggling to eat their meal and then they walked away from it. We later saw a staff member enter the room and remove the plate and placed it on the trolley. Another staff entered the room and assisted one person with their meal but they had their back turned to the other people in the room. They did not see that people were struggling with their meals. One person was sat with their meal on their lap and they didn't eat it. Forty five minutes later the activities coordinator entered the room and we brought this to their attention and they supported the person to eat their meal.

Two people told us they wanted a drink but there were no staff nearby to get them one. We requested a drink on their behalf. We saw drinks were not readily available in the lounges and the regional manager acknowledged this and said this would be addressed

We shared these concerns with the regional manager who said this would be addressed with the staff team. The regional manager said where they had concerns that people were not eating or drinking enough, charts would be put in place to monitor this. The charts we looked at showed consistent recordings of what people had eaten and drank. The regional manager said that the nurses were responsible to reviewing the monitoring charts and this was confirmed by two nurses we spoke with.

Requires improvement

Is the service effective?

People said they had access to other healthcare services when required. One person said, "Staff will always call the doctor if I need one." The care records we looked at showed when healthcare professionals had visited the individual. One person told us they had access to their GP when needed but had not seen an optician for at least four years and said, "My glasses are no longer adequate." The person's care record showed they were seen by an optician two years ago and we shared this information with the nurse in charge. They assured us arrangements would be made for the optician to visit.

Inadequate

Is the service caring?

Our findings

Although staff told us they were aware of the importance of respecting people's privacy and dignity they did not demonstrate this during our inspection. Staff did not interact with people unless they were carrying out a task with them. When staff entered rooms they did not speak to people. When people required staff's attention by calling out or by their body language, this was ignored. Whilst a person was eating their meal their face became unclean. Staff did not take any action to preserve the person's dignity and we asked staff to assist them. Staff told us that people were not supported in a timely manner to manage their continence needs and this compromised people's dignity. A person who was living with dementia did not receive appropriate catheter care. We saw their catheter bag was exposed and in full view of other people as they walked by their bedroom. The catheter bag was so full the urine had started to flow back into the tubing because it had not been emptied in a timely manner. When we brought this to a staff member's attention they took immediate action to address this. The regional manager acknowledged that this placed the person's health at risk.

People who were unable to ask for care and support did not always receive it and staff were unsympathetic to their needs. Staff failed to recognise one person's needs and the support they required to eat their meal. One staff member told us that a person was unable to use their right hand but staff placed the person's meal on their right side and they could not reach it using their left hand. Although we brought this to the staff member's attention they did not take any action to address this and the person was unable to eat their meal. Four people who were unable to tell us about the service they had received and were reliant on staff to assist them with their personal care needs did not receive the appropriate support. Their finger nails were long and unclean. We shared this information with the regional manager who said this had been addressed with staff a few days prior to our inspection but staff had not acted on this. Two people told us they were not able to have a shower when they wanted one. One person said, "I have a shower when they say." Another person told us, "I am asked infrequently whether I would like a bath or shower. Privacy locks were not fitted to all toilet doors and one staff member did not recognise this was an infringement of people's privacy. They told us that toilets allocated for staff had a lock on the door but not toilets allocated for people who lived there. They thought this was acceptable because people may lock themselves in.

Two people told us, "There are too many agency staff who don't know what they are doing." The permanent staff we spoke with had a good understanding of people's care needs but the agency staff didn't. This was of concern because on the first day of our inspection one out of two nurses on duty were agency workers and three out of six care workers were from an agency. We looked at the care of one person who was living with dementia. The person was unable to tell us what their care needs were. We spoke with an agency worker who told us they had not been informed of the person's care needs and didn't know what they were. This lack of knowledge meant the person was at risk of receiving poor care because the staff responsible for their care that day was unaware of their needs. We spoke with two care workers who told us it was difficult working with agency workers because they were unware of people's needs. They said this meant them having to spend a lot of time telling and showing agency workers what to do rather than caring for people living at the home.

This is a breach of regulation 10, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four people told us they were unaware of their care plan and were not involved in their care planning. One person said, "I have never seen my care plan." One staff member confirmed that people were not always formally involved in planning their care but the regional manager said they were. The regional manager showed us evidence that one person had signed their care plan to show their involvement. We saw another care record that showed the person was living with dementia and their family had been involved in planning their care. One person confirmed their involvement in their care planning but this did not apply to everyone and people were at risk of not receiving care and support the way they liked.

People told us they were happy with the service provided to them. One person said, "It's nice living here and the staff are kind." We spoke with a visitor who said, "I have no concerns about the service provided to my friend and they are well looked after." Another person told us, "The staff are very nice." A visitor told us that although the staff

Inadequate

Is the service caring?

appeared very busy they were happy with the care their relative had received. We also saw one good practice where staff supported a person with their mobility and this was carried out in kind and respectful way.

Requires improvement

Is the service responsive?

Our findings

People and staff confirmed that not everyone was involved in the assessment of their care. One person said they had not been involved in the assessment of their care but were happy with the support they had received. We asked one relative about their views about communication in the home. Their relative had a large bruise on their face and they told us that staff would not tell them what had happened and asked us to help them find out. When we spoke with the staff and the regional manager they were unaware of how the person had sustained this injury. The regional manager later informed us that the person had injured themselves the previous day. The person's care record did not provide robust information about how this injury had occurred or what treatment was given and the regional manager was unable to provide us with further information.

People told us they had limited access to their local community. One person said due to their disability they were unable to go out alone and staff did not support them to do this. Staff told us there were not enough staff on duty to support people to maintain links with their local community.

Two people told us that activities had significantly reduced over the past few months and said, "It's a bit boring." They said they thought the lack of activities was due to there not being enough staff on duty. A staff member said, "People are not involved in meaningful activities." They said staff only had time to meet people's basic care needs and told us, "I wouldn't like my parents to live here." One person said, "An entertainer visits the home once a month."

Another person said they didn't do much during the day and told us, "I just sit and rest." A staff member said, "We have been asked to carry out social activities today because the inspection team are here but we don't have the time." We spoke with a visitor who said there were very little activities and their relative had told them they were bored. They said, "Although I am happy with the care, people could do with more stimulation." The provider had appointed an activities coordinator who had been in post a month. They were enthusiastic about their role and said they had discussions with staff from the memory clinic to find out about suitable activities for people living with dementia. They told us they were in the process of identifying people's interests and what they would like to do. They said that due to poor staffing levels they were unable to pursue their role and often had to support the care staff to assist people with their care needs.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us they were unaware of the complaints procedure but said, "I would share my concerns with the staff, they do listen to you and sort things out." Another person told us they had no concerns but if they did they would tell the staff. The provider's complaint procedure was located throughout the home but the people we spoke with were unaware of the procedure. The provider was unable to tell us how they ensured people knew how to share their concerns. Discussions with the regional manager and the records we looked at showed that complaints were recorded and responded to and identified action taken to resolve them.

Inadequate

Is the service well-led?

Our findings

One person told us they were unaware of who was running the home due to changes in the management structure but they were happy living there. The provider did not have a registered manager in place. The regional manager said the new manager would commence post in February 2016. The home was managed by an interim manager until the appointment of the new manager. One person said, "We have lost a lot of good staff because of poor management." One staff member said they had several managers and there was no clear leadership and they felt unsupported. Another staff member said, "It is demoralising not having a manager." Staff told us that managers running the home were unapproachable and a 'do not disturb' sign was always attached to the office door and we saw this sign in place. We shared this information with the regional manager who removed the sign from the office door.

There was no clear leadership to ensure staff were aware of their role and responsibilities and the regional manager acknowledged this. For example, staff told us that not everyone was aware of what was expected of them or what their responsibilities were. Three staff members told us that staff morale was low and they felt this had an impact on the quality of service provided to people. One staff said, "People do hear us moaning and that's not good." Staff said they didn't feel that the managers listened to them. They said their concerns about staffing levels and the lack of support had not been acknowledged.

The provider had an internal quality assurance audit system but this was not effective enough to make sure people received a safe and effective service. There were no systems in place to ensure staff were available at times to support people when needed. The regional manager acknowledged that the deployment of staff had not been managed properly and said this would be looked at. Although discussions with the regional manager confirmed they knew when to inform us of incidents that had occurred in the home and when to share concerns about abuse with the relevant agencies. The regional manager was aware of when to send us a statutory notification to tell us about important events which they are required to do by law.

We looked at how people were involved in the running of the service and how the provider engaged with them. The regional manager said meetings were carried out with people who used the service. One person said, "We don't have meetings but the staff do." Records showed that one meeting had been carried out in one year. The regional manager said meetings were carried out with the staff team and staff confirmed this.

There was no structured induction in place to ensure all new staff were provided with training to inform their learning and how to care for people. Staff did not receive regular supervision and felt unsupported within their role. One staff member said they had been in post six months and had received one supervision session. They said this was due to not having a manager in post and the regional manager acknowledged this. We saw that staff were not managed to provide an effective service and some staff showed little compassion for people's needs. People's interests and hobbies had not been explored to ensure they were supported to maintain this and they were not provided with stimulation.

The regional manager said that complaints were regularly audited but confirmed there were no specific systems in place to identify trends. We found that accidents had been recorded but the regional manager confirmed that there had been a lack of consistency in monitoring accidents to identify trends because of the absence of a manager. However, the regional manager said for the last three months an accident analysis had been carried out. This gave them the opportunity to identify the types of accidents that had occurred and to take action to avoid this happening again.

This is a breach of regulation 17, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** **Dignity and respect** **People were not treated with dignity and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 HSCA (RA) Regulations 2014** **Good governance** **The provider did not have robust or effective quality assurance monitoring systems in place to ensure people received a safe and effective service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014** **Staffing** **There were not enough staff on duty to ensure people's care and support needs were met and this placed people at risk of inadequate care.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA (RA) Regulations 2014**

This section is primarily information for the provider

Action we have told the provider to take

Person-centred care

People were not included in the planning of their care and were not supported to pursue their hobbies and interests.