Edgemont House Limited

Edgemont House

Inspection report

Edgemont House
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Bristol
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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 12 and 16 May 2016 and was unannounced. There were no concerns at the last inspection of September 2013. Edgemont House is registered to provide accommodation for up to 13 older people. At the time of our visit there were 14 people living at the service. The registered provider had redesigned space within the home to accommodate another bedroom with en-suite facilities. However they had failed to apply to the Commission to increase their numbers and were in breach of their registration conditions.

A manager had been appointed in September 2015; however they had not registered with the Commission. 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.

Despite the positive views of people who used the service improvements were required. We could not be satisfied that people were always safe because the care staffing levels did not take into account unforeseen circumstances or emergencies. The way staffing levels were considered needed to be reviewed to take into account dependency levels of people who required care and support.

Monitoring the quality of the service had lapsed; they had not been consistently applied and were not robust enough to ensure quality and safety. People's views and experiences were not sought through quality assurance systems. The provider lacked knowledge and understanding about their legal obligations, including conditions of registration.

People were 'happy and content' living at Edgemont House and we received positive comments about their views and experiences during our visits. People said staff were 'attentive and angels'. One person said, "I feel like this is my home and I have a big family".

Staff were knowledgeable in safeguarding procedures and how to identify and report abuse. People were supported by the recruitment policy and practices to help ensure that staff were suitable.

People were helped to exercise choices and control over their lives wherever possible. Where people lacked capacity to make decisions Mental Capacity Act (MCA) 2005 best interest decisions had been made. The Deprivation of Liberty Safeguards (DoLS) were understood by staff and appropriately implemented to ensure that people who could not make decisions for themselves were protected.

People received a varied nutritious diet, suited to individual preferences and requirements. Mealtimes were flexible and taken in a setting where people chose. Staff took prompt action when people required access to community services and expert treatment or advice.

People enjoyed receiving visitors and had made "friends" with people they lived with. They were relaxed in each other's company. Staff had a good awareness of individuals' needs and treated people kindly. Staff were knowledgeable about everyone they supported and it was clear they had built up relationships based on trust and respect for each other.

People moved into the service only when a full assessment had been completed and the registered manager was sure they could fully meet a person's needs. People's needs were assessed, monitored and evaluated. This ensured information and care records were up to date and reflected the support people wanted and required.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We have also made recommendations in the report where improvements are required. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe because appropriate action was not taken to ensure there were enough care staff to support people.

Staff had received training in safeguarding so they would recognise abuse and know what to do if they had any concerns.

People received care from staff who took steps to protect them from unnecessary harm. Risks had been appropriately assessed and staff had been provided with clear guidance on the management of identified risks.

People were protected through the homes recruitment procedures. These procedures helped ensure staff were suitable to work with vulnerable people.

People were protected against the risks associated with unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

People received a standard of care from staff who understood their needs and preferences. Staff were encouraged and keen to learn new skills and increase their knowledge and understanding

People made decisions and choices about their care. Staff were confident when supporting people unable to make choices themselves, to make decisions in their best interests in line with the Mental Capacity Act 2005.

People had access to a healthy diet which promoted their health and well-being, taking into account their nutritional requirements and personal preferences.

The service recognised the importance of seeking advice from community health and social care professionals so that people's health and wellbeing was promoted and protected.

Is the service caring?

Good

The service was caring.

The manager and staff were committed to providing people with the best possible care.

Staff were passionate about enhancing people's lives and promoting their well-being.

Staff treated people with dignity, respect and compassion.

People were supported to maintain relationships that were important to them.

Is the service responsive?

Good

The service was responsive.

Staff identified how people wished to be supported so that it was meaningful and personalised.

People were encouraged to pursue personal interests and hobbies and to join in activities.

People were listened to and staff supported them if they had any concerns or were unhappy

Is the service well-led?

Requires Improvement

The service was not always well led and improvements were required.

The provider lacked knowledge on their responsibilities under their conditions of registration with CQC.

Effective quality monitoring systems were not in place. Feedback had not been encouraged by people who used the service.

Audits were not being completed to regularly assess the quality and safety of the services provided.

People and staff felt supported by the manager.

Edgemont House

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

This service was previously inspected in July 2014. At that time we found there were no breaches in regulations. This inspection took place on 12 and 16 May 2016 and was unannounced. One adult social care inspector carried out this inspection.

Prior to the inspection we looked at information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they planned to make. We reviewed the information included in the PIR and used it to assist in our planning of the inspection.

During our visit we met and spoke with everyone living at the home, and visiting health care professionals. We spent time with the manager and all staff on duty. We looked at people's care records, together with other records relating to their care and the running of the service. This included staff employment records, policies and procedures, audits and quality assurance reports.

Requires Improvement

Is the service safe?

Our findings

We could not be satisfied that people were always safe because the staffing levels did not take into account unforeseen circumstances or emergencies. On the first day of our visit one person who had dementia was very anxious and distraught. The manager described the person's rapid decline over the previous 72 hours and urgent referrals had been made so that the person could be assessed by the community psychiatric team and a social worker. The staffing levels had not been reviewed to enable the person to be supported effectively and safely. It was by chance that a member of staff had arrived for duty by mistake later in the day which meant this person had the one to one support required. Previous to that one to one support had been given however this meant that there was only one care staff member available to meet the needs of the remaining 12 people living in the home. This meant there was a risk that people would not receive the care and support they needed at this time. By the end of our first day, additional funding had been sourced and an extra staff member had been deployed to provide one to one support for the person whose dementia had declined.

We spoke with people, staff and visiting health and social care professionals. Comments indicated some concerns around 'availability of staff' and that staff were 'stretched' at certain times of the day. These were referred to as the 'busy times', for example first thing in the morning when people wanted to get up and have breakfast and again at lunchtime. Staff felt that during these times a person centred approach was sometimes compromised due to time constraints and a lack of staff availability.

During feedback at the end of our visits the manager and provider agreed that the care staff levels needed to be reviewed to take in to consideration certain factors. This included dependency levels of people, the skill mix, the layout of the home, leadership during the shift, and review of daily routines so that care support was not compromised. They also needed to take into account that people's needs were increasing requiring more staff support, for example with people's mobility and personal care.

This was a breach of Regulation 12 of the Health and Social care Act 2008 (regulated Activities) Regulations 2014.

Staff wanted to protect people and keep them safe. They had received safeguarding training and had access to policies and procedures for guidance. Information was available about who to contact should they suspect that abuse had occurred. The manager and staff recognised their responsibilities and duty of care to raise safeguarding concerns if they suspected an incident or event that may constitute abuse. Agencies they would notify included the local authority, CQC and the police.

The manager and staff had good systems in place for reporting accidents, incidents or concerns. Written accident and incident documentation contained a good level of detail including the lead up to events, what had happened and what action had been taken. Any injuries sustained were recorded on body maps and monitored for healing. We saw a clear process where all incidences were evaluated over a 72-hour period. Some injuries sustained would be reviewed for longer where necessary until healed.

Staff encouraged people to live as independently as possible and recognised this could expose people to some degree of risk. People were supported to take risks balanced on their safety and their care needs. The manager shared with us the most recent example where this was demonstrated. One person who had been self-medicating had discussed with the manager that they were no longer confident to manage their own medicines. Following an assessment and support from the manager this decision was respected. Another person wanted to retain their independence around mobility but they were at risk of falls. The manager and staff had considered walking aids, footwear and a safe environment whilst supporting this person's wishes. Staff understood specific risks relating to people's health and well-being and how to respond to these. This included risks associated with weight loss and maintaining skin integrity. People's records provided staff with information about these risks and the action staff should take to reduce these.

Staff files evidenced that safe recruitment procedures were followed at all times. Appropriate pre-employment checks had been completed and written references were validated. Disclosure and Barring Service (DBS) checks had been carried out for all staff. A DBS check allows employers to check whether the applicant has had any past convictions that may prevent them from working with vulnerable people.

Policies, procedures, records and practices demonstrated medicines were managed safely. There had been no significant errors involving medicines in the last 12 months. Staff completed safe medicine administration training before they were able to support people with their medicines. Staff were observed on all medication rounds until they felt confident and competent to do this alone. The manager also completed practical competency reviews with all staff to ensure best practice was being followed.

Good

Is the service effective?

Our findings

New staff had an induction programme to complete when they started working at the home. The programme consisted of 15 modules to be completed within three months and was in line with the new Care Certificate introduced for all care providers on 1st April 2015. A mentor system was also in place where all new staff were linked with and shadowed by a senior staff member during shifts. This was to assist with continued training throughout the induction process and to consolidate their learning.

Staff were encouraged and supported to increase their skills and gain a diploma in health and social care at level two or three (formerly called a National Vocational Qualification). In addition to mandatory courses, staff studied additional topics to help them understand the conditions and illnesses of the people they cared for and to enhance their skills. This included dementia awareness, person centred care, and supporting behaviours that challenge. The manager had accessed training through a mix of training providers. Staff were enjoying the training available comments included, "The training has been very useful and enjoyable" and "Really pleased with training so far, the content has been good and helped me a lot".

Staff we spoke with felt they were supported by the manager and other colleagues. Additional support/supervision was provided on an individual basis and these sessions were formally recorded. Supervisions supported staff to discuss what was going well and where things could improve, they discussed people they cared for and any professional development and training they would like to explore. Staff meetings were an additional support network, where they shared their knowledge, ideas, views and experiences.

The manager and staff understood the principles of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for those acting on behalf of people who lack capacity to make their own decisions. The DoLS provide a legal framework that allows a person who lacks capacity to be deprived of their liberty if done in the least restrictive way and it is in their best interests to do so.

People's legal rights were respected and any restrictions were kept to a minimum using the least restrictive option. Where applications had been authorised to restrict people of their liberty under the DoLS it was to keep them safe from possible harm. There was a clear account about why referrals had been made and how a person had been supported through the process and by whom. This included GP's, best interest assessors and or independent advocates. There were systems in place to alert the manager when DoLS would expire and needed to be re-applied for.

There were no restrictive practices and daily routines were flexible. People were moving freely around their home, spending time together and with staff and visitors. They chose to spend time in the lounge, the dining room, the sun room, their own rooms and the garden.

People told us they 'loved' the food and they chose what they had to eat. One person said, "All the food is very good, it's like a restaurant service". Menus reflected seasonal trends and meals that people had chosen

were traditional favourites. Food was often purchased on a daily basis and everyone was asked by staff if there was anything they would like in particular. Staff told us they often diverted from menus because people changed their minds and this was always respected. Staff knew people's personal preferences, likes and dislikes. This included things like snacks, crisps, sweets and drinks. One person had recently asked for a bottle of Baileys to enjoy a nightcap and we saw another person enjoying a half pint of bitter and their favourite cheese and onion crisps.

Mealtimes were flexible wherever possible and people were supported if they wished to receive meals in their rooms. The dining room was popular with people and they enjoyed dining together. They were always asked after each mealtime if they had enjoyed their food.

Weights were checked monthly but frequency increased if people were considered at risk. The manager gave us examples of when referrals had been made to specialist advisors when required. This included speech and language therapy when swallow was compromised and GP's and dieticians when there were concerns regarding people's food intake and weights.

The manager and staff recognised the importance of seeking expert advice from community health and social care professionals so that people's health and wellbeing was promoted and protected. The home ensured that everyone had prompt and effective access to primary care including preventative screening and vaccinations, routine checks, GP call outs and access to emergency services. People were supported to register with GP's and dentists of their own choice. Referrals had been made to speech and language therapists and community dieticians. Opticians and dentists were accessed to provide regular check-ups and treatment where necessary. Two healthcare professions told us staff were very helpful when they visited and responded well to any guidance on care and support. They confirmed staff had people's best interests at heart and they cared about people.

Good

Is the service caring?

Our findings

We were introduced to people throughout our visits and spent time observing them in their home. The atmosphere was relaxed and people appeared comfortable and confident in their surroundings. Staff were caring and kind. We received positive comments about staff which included, "They deserve a medal, I can't complain about anything", "They are all very good to me and they make me smile" and "I am very happy and I am treated well". One visiting health professional told us, "The staff are professional, kind and work very hard".

We asked staff what they thought they did well and what they were proud of. Comments included, "It's a small home and there's a personal touch", "I want people to feel special this is their home after all" and "I love my job, I enjoy every minute of it, it's satisfying".

During our visits we saw staff demonstrating patience and kindness. One person who had dementia had become increasingly anxious and distressed. Staff repeatedly offered words of reassurance and used gentle persuasion techniques to try and relieve their anxiety. Their approach was calming, sensitive and respectful. Conversations and banter were jolly and interesting. We overheard one staff member talking with two people about trips abroad and they were sharing camping holiday stories.

People were smartly dressed and looked well cared for. They were supported with personal grooming and staff had maintained those things that were important to them prior to moving in to the home. This included preferred style of clothes that were clean and ironed, shaving, manicures and weekly sessions with a hairdresser.

The manager spoke with us about the new keyworker roles and how this would enhance a personalised approach. Staff were getting to know the people they supported well and their knowledge of needs both physically and emotionally was good. The manager and staff recognised that people needed a purpose and wanted them to continue with things that were important to them so that their lives remained meaningful. They considered personal preferences and interests that people had prior to moving into the home. One person who used to be a carpenter had recently made a large bird feeding table which sat 'proudly' in the homes garden. We spoke with the person who told us they had 'thoroughly enjoyed making it' and they were looking forward to the next project. Other examples included supporting a person who had always enjoyed baking and another who was a keen gardener.

Staff provided us with a good level of detail about people's family support and existing relationships prior to moving into the home. Every effort was made to ensure relationships remained important. The manager spoke with us about how they had recently been supporting a family who were coming to terms with their parent requiring full time care. The manager's sensitive approach had helped them build relationships of trust in order to help relieve feelings of anxiety. Visitors were welcome any time. People saw family and friends in the privacy of their own rooms, communal areas and the garden. One relative told us, "I enjoy visiting and always feel welcomed. Staff are very caring".

Good

Is the service responsive?

Our findings

The manager completed an assessment for those people who were considering moving into the service. Significant people were part of the process including family, hospital staff, GP's and social workers. The information gathered supported the manager and prospective "resident" to make a decision as to whether the service was suitable and their needs could be met. The assessments assisted staff to develop care plans based on individual needs; they were reviewed and further developed during the first four weeks of admission.

Care records were fairly detailed and would help support the staff to deliver care effectively, where wishes and choices were respected. Following additional training the manager and staff were in the process of developing these further so that there was more individualised detail. This included the level of assistance required and preferred routines. Preferred night time routines had been considered and people had been asked what would make them comfortable and feel safe. This covered aspects such as what time they wanted to go to bed, closing bedroom doors, whether people preferred a light on or a window open and how many times they wanted to be checked at night. Comments from people included, "They always do what I ask, they are very good like that" and "They know all the little things that are important to me".

The manager had increased the hours of support for planned activities per week from six hours to 14. Everyone agreed that there should be more trips out and this had been actioned. People had been asked for suggestions on preferred places to go. Requests included museums, coffee shops, Weston-Super-Mare, shopping trips and garden centres. People had also asked for a garden party in the summer and a royal tea to celebrate the Queens 90th birthday.

People told us popular activities included arts and crafts, bingo, reminiscence discussions, and quizzes. We saw people enjoying their own interests for example reading and knitting. One person enjoyed poetry and staff were arranging a poetry day. Entertainers visited every month to perform and children came from a local school to celebrate Harvest Festival and Christmas. Church members visited the home either to perform a service or to spend time with people individually. Some people preferred to visit church and attend services.

The service had a complaints and comments policy in place and people and their families were given a copy on admission. People told us they were happy to speak with all staff about any concerns and were confident these would be acted on. The manager encouraged people to express concerns or anxieties so they could be dealt with promptly. This approach helped prevent concerns escalating to formal complaints and relieved any anxiety that people may be feeling. They also spent time around the home and saw people every day to see how they were. Small things that people may be worried about or made them unhappy were documented in the daily records and provided information about how they had been dealt with. This information was also shared with staff in shift handovers. More formal concerns were documented in the complaints folder.

The service had not received any serious complaints in the last year, but some people shared concerns

where improvements could be made. One relative had expressed concerns because they had not been informed that their relative had seen a GP whilst they were away on holiday. The manager updated the person's records to reflect that the family would like to be informed of any GP visits at all times whatever the outcome. One person felt their relative's bedroom had looked untidy when they visited, and the manager had also noticed that beds look untidy when they had been made in the mornings. This had been resolved by introducing a system whereby 'spot checks' for all rooms were put in place and staff had a learning set on correct bed making.

Requires Improvement

Is the service well-led?

Our findings

On the first day of our inspection we were shown around the home to look at the improvements made to the environment over the last year. During the tour we saw that a room that was previously used for laundry services had been refurbished into a bedroom with en-suite facilities. The room had been in use since September 2015. This had increased the occupancy from 13 to 14. The provider had not applied to the commission to vary their conditions of registration.

This was a breach of section 33 of the Health and Social Care Act 2008.

In addition to this the provider had failed to notify the commission with an amended statement of purpose to reflect these changes.

This was a breach of Regulation 12 Care Quality Commission (Registration) Regulations 2009.

During the past 18 months both the previous registered manager and deputy manager had left to pursue other roles and for personal reasons. Provider visits had continued but they did not capture where improvements were required. They needed to be more robust in order to support the new manager. The inconsistencies around management presence and oversight meant that some previous practices around quality assurance and audits had lapsed. Audits help to assess and monitor the safety of the services provided. For example, there were good systems to record accident and incidents but, these were not audited. There was no evidence of learning from incidents that took place, so that appropriate changes could be implemented. Audits would have helped identify any trends to help ensure further reoccurrences were prevented.

The provider was not actively seeking the views of people, relatives, staff, visiting professionals or commissioners about their experience and the quality of care delivered by the service. This had previously been achieved by sending questionnaires, followed by analysis and any action/response required based on the information received.

This was a breach of Regulation 17 of the Health and Social care Act 2008 (regulated Activities) Regulations 2014.

We recognised the work and improvements the manager had made since starting in September 2015, and the improvements and investment the provider had made to the environment over the last year. However having met with the nominated individual and one of the five directors it was clear that the providers knowledge of their responsibilities and accountability to the CQC was limited and required improvement. This included details of the CQC's Key Lines of Enquiry, the Health and Social Care Act 2008 (regulated Activities) Regulations 2014, and the Care Quality Commission (Registration) Regulations 2009 (Part 4).

The service has a condition of registration that there must be a manager registered with the CQC, and an application must be made to the CQC as soon as they are carrying on a regulated activity. Although the

manager had been appointed in September 2015, the CQC had not received an application.

The provider had not followed a formal system through supervisions/discussion with the manager where future plans should have been discussed and implemented in a timely manner.

We recommend that the provider increases their knowledge and understanding on how CQC monitor, inspect and regulate their service to make sure they are meeting the fundamental standards in order to ensure they are providing safe, quality of care.

In some aspects the new manager had received an induction. This had been slightly compromised because the notice period of the previous registered manager did not overlap with the appointment of the new manager. Subsequently this meant that a lot of essential information about the responsibilities for manging the home had not been covered. In some instances the manager had used their initiative and taught themselves through internet research, talking with other managers of care services and contacting health and social care professionals in the community. This included the local authority and CQC. When we spoke with the nominated individual and one of the directors, they hadn't been aware that the manager's induction had not been fully completed. This did highlight that effective support and communication between themselves and the manager required improvement.

We recommend that a formal supervision system is put in place where all discussions and any actions required are clearly documented.

We received positive feedback about the manager. Staff explained how initially the change in management had been 'a little unsettling' but that things were 'starting to fall into place'. Comments included, "I find the manager very supportive and caring", "I am confident to speak with the manager, she is very approachable and easy to talk to" and "I couldn't ask for a better boss". One person living in the home said, "The person in charge is a sweetheart, they are all lovely to be honest".

Options around a management structure were still being considered and the deputy position had not been redeployed. A new part time role had been created for a personal assistant (PA) to work alongside and support the manager in operations and administration. It was good to see both the manager and PA working together and brainstorming ideas together. They were involving all staff in meetings and small impromptu discussions. We saw various examples where staff had been listened to, action had been taken and improvements had been made. Examples included, introducing the keyworker approach, promoting person centred care, improved systems and storage of medicines and sourcing additional equipment and supplies.

The manager wanted to 'get a feel' for what it was like for staff working on their shifts. This had helped them evaluate the levels and quality of care given, understand the routines and assess where improvements could enhance care and quality for people and staff. They spoke with us about a recent night shift they had worked and how simple solutions had been initiated to support effective, safe care. This included the introduction of walkie talkies so that staff could ask for assistance from another, rather than walking around the home at night looking for a colleague.

We found there had been significant improvements in the environment to enhance the living conditions for people. An old existing conservatory had been replaced with a large, bright sunroom. This room was very popular with people, affording them a peaceful atmosphere looking out over a pretty well maintained garden. One person told us, "It's my favourite place to sit and read, very calming".

One bathroom had been extensively refurbished and now provided people with a large wet room for showering. Existing space within the home had been changed to provide an additional bedroom with en-suite facilities and a new laundry facility. There was a continuing programme of redecoration throughout the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 Registration Regulations 2009 (Schedule 3) Statement of purpose The registered provider had not updated their statement of purpose.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Section 33 HSCA Failure to comply with a condition The registered provider had failed to comply with their condition of registration. They were accommodating 14 service users but were only registered for up to 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider does not ensure that sufficient staff are available to meet service users needs safely. Regulation 12 (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider did not have effective systems in place in order to assess and monitor the services they provide.