Sundridge Developments Limited

Edenvale Nursing Home

Inspection report

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Date of inspection visit:
25 October 2018

Date of publication:
07 August 2019

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

What life is like for people using this service:
• The quality of care people received had significantly deteriorated since the last inspection.
• People had been placed at risk of avoidable harm. Medicines were poorly managed, placing people at risk.

• The culture in the service was poor. Staff were task orientated and supported by a management team who lacked clear oversight and knowledge of what was happening in the service.
• Some people had experienced harm because of poor practice and ineffective governance systems and processes.
• The service met the characteristics of inadequate in all areas we inspected.
• Please see more information in Detailed Findings below.

Rating at last inspection: The service was last rated Good, published on 17 May 2018.

About the service:
Edenvale Nursing Home is a care home that was providing personal and nursing care to 28 people at the time of the inspection. It is registered to provide a service to older people who may be living with dementia, physical disability and mental health needs.

Why we inspected:
This inspection was brought forward in response to incidents that had occurred in the service and concerns that had been raised about the safety and management of the service. At the time of the inspection we were aware of incidents being investigated by third parties.

Follow up:
Following the inspection we referred our concerns to the local authority responsible for safeguarding. In addition, we requested an action plan and evidence of improvements made in the service. This was requested to help us decide what regulatory action we should take to ensure the safety of the service improves.

The overall rating for this registered provider is 'Inadequate'. This means that it has been placed into 'Special Measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
• Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

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.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider and registered manager following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our findings below.

Edenvale Nursing 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 checked 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 was carried out by two inspectors, a medicines inspector and an expert by experience who had personal experience of using or caring for someone who uses services that support people with dementia.

Service and service type:
Edenvale Nursing Home is a care home. People in care homes receive accommodation and nursing or personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection:
The inspection was unannounced. Inspection site visit activity started on 25 October 2018 and ended on 25 October 2018.

What we did:
Prior to the inspection we reviewed any notifications we had received from the service and information we had received from external agencies including the local authority and clinical commissioning group (CCG).

This inspection included speaking to seven people, 11 relatives or visitors, five staff, the registered manager and provider. We also reviewed records related to the care of 12 people. We looked at records of accidents and incidents, audits and quality assurance reports, complaints, four staff files and the staff duty rota for the previous month. We also looked at documentation related to the safety and suitability of the service. We spent time observing interactions between staff and people within the communal areas of the home.

After the inspection we requested further information from the registered manager and provider. Not all of the information was received for example, we requested policies and procedures from the provider and

registered manager on two occasions but were unable to review these as they were not received at the time of writing the report. We requested an action plan from the provider and registered manager to see what action would be taken to improve the service. The report includes evidence and information gathered by the other inspector, medicines inspector; Expert by Experience; and from communication with the local authority and CCG.

Inadequate

Is the service safe?

Our findings

People were not safe and not protected from avoidable harm. Some people told us that they felt safe in the service however, despite this feedback we found significant concerns about the safety of the service. We observed documented feedback from one relative which noted, 'I feel disappointed, frustrated and let down that my [relative's] one to one care has not been chased up with [external agency]. It has taken a fourth serious fall for this to be considered urgent'.

Systems and processes:
• People were at risk of avoidable harm. There had been multiple falls, injuries and incidents in the service since the last inspection concluded in May 2018. There were many examples where people had fallen, sustained injuries or been placed at risk of harm due to the registered manager, provider and staff not ensuring appropriate measures were in place to reduce these risks, or where staff had not followed the person's care plan.
• The knowledge of the registered manager and senior staff around falls prevention was poor. The service relied upon outside agencies to improve the safety of people and those agencies found numerous concerns with care being provided. The service did not proactively act on concerns and following the inspection, further concerns were raised about the management of falls.
• No staff had received training in falls awareness and prevention for over a year. Considering the concerns about falls within the service, this demonstrated a lack of recognition of the risks by the registered manager and provider and a failure to ensure staff had received training to ensure they had the skills and competence to mitigate risks to people.
• There was a poor induction of agency staff. One person had a fall in the service because their preferences had not been handed over to agency staff who were not prevented from supporting that person inappropriately. One person told us "the agency staff don't know what they're doing".
• The above concerns were brought to the attention of the provider and registered manager. Assurances were sought from the provider to ensure the safety of people using the service. Subsequent to the inspection, we sought an action plan from the provider which advised that some actions had been implemented to mitigate the risk of harm. For example, falls awareness training had been booked and agency staff now received a handover outlining those people at risk of falling. Despite these measures being taken, they take time to be embedded and sustained.
• The above concerns demonstrated a failure to prevent avoidable harm or risk of harm which was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Assessing risk, safety monitoring and management:
• Staff were not able to appropriately recognise deterioration in people and act accordingly. There were examples where registered nurses had contacted 111 instead of 999 in an emergency. One person told us medical concerns were addressed, "Only if [staff] say I need it. I needed to go to hospital in my estimation and they said I wasn't bad enough". We observed one person who had sustained a head injury. It is important following a head injury that clinical observations are taken to monitor for signs of health deterioration. Staff had not undertaken these observations for this person. The registered manager had not recognised this as a concern.

• Staff had not recognised the physical deterioration for a person for fifteen months. Staff had not sought appropriate professional support in a timely manner and the staff member we spoke to was not aware of the condition the person was living with. Following a visit to the service by an external professional, this person's condition was reviewed and recommendations were made in October 2018. Despite this 23 days later we found that not all these recommendations, appropriate referrals and measures to prevent further deterioration had been implemented at the time of our inspection. This resulted in a poor outcome for the person and placed them at a continued risk of harm. This was discussed with the registered manager and provider and they did not provide a reason for measures not in place.
• Medical investigations, such as blood tests were not always carried out in a timely manner.
• Staff did not ensure that equipment to improve safety was consistently in place such as call bells and movement sensors. One relative told us about sensor mats that should have been in place for their relative, "I've had many incidents when there's been no [sensor] mats on the floor". During the inspection a member of staff was unable to show us how to turn a sensor on. A person sustained a fall after the inspection due to sensors not being used appropriately to monitor the person's safety. This demonstrated continuing ineffective use of those sensors and the registered manager expressed frustration to us that this poor practice was continuing.
• Staff did not make appropriate referrals to other professionals. For example, one person who was at risk of choking was on a special diet to reduce the risk. Staff had changed the diet to one that carried more risk without consulting a speech and language therapist first.
• A failure to ensure risks associated with people's care were assessed and plans implemented and delivered to mitigate the risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely:
• We saw one person who had not been given their medicine for Parkinson's Disease as it had not been in stock. The CCG audit also identified this medicine had run out in the previous month. This demonstrated poor management of medicines as the service had not learnt from the mistake in the previous month and not ensured this person had vital medicines available to manage their health.
• There was no information available to guide staff on when medicines that are prescribed to be taken 'when required' should be given. We saw that one person who had been prescribed a medicine for anxiety had been given more than the daily dose prescribed. When identified by us the registered manager began an investigation.
• Creams and other external preparations were applied by carers. There were no directions to show where they needed to be applied. There were also no administration records on the day of inspection so it was not possible to say if creams were being applied as prescribed. Creams were being stored in people's bedrooms and we saw that two creams had expired.
• Medicines were stored securely in a locked treatment room. Nurses recorded the fridge temperature daily, however the minimum and maximum had not been recorded. There were also some gaps in the recording so the records could not give assurance that medicines requiring cold storage were kept at appropriate temperatures. On the day of the inspection the maximum fridge temperature was outside the recommended range. When creams, eye drops and liquid medicines were opened the dates were not always recorded to ensure they were discarded within the required time range. There were suitable arrangements in place to manage medicines which required extra security.
• Some people were receiving covert medicines (medicines given without their knowledge). A pharmacist had not always been consulted on the best way to administer these medicines as recommended by the provider's medicines policy. This meant we could not be assured the medicines effectiveness was not being affected.
• The above concerns were brought to the attention of the provider and registered manager and following the inspection, we sought assurances that action had been taken to safely manage medicines.

• The failure to ensure the safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong:
• Accidents and incidents were poorly documented, could not be clearly analysed and lessons learnt were not documented. We observed a document called 'Whole home falls audit' that was poorly completed and did not include any analysis of factors involved in the falls. We brought these concerns to the attention of the provider during the inspection and following the inspection and requested they take action.
• A failure to conduct an effective analysis meant lessons were not learned and improvements not made. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels:
• We asked people if they thought there were enough staff to support them. Comments included, "No, because you have got to wait a long time when you push the buzzer. They say, 'You're not the only one.' As far as I know, I never claimed to be" and "Someone comes and starts with you and then they say they've got to go to so and so and then they don't come back. That happens quite often."
• There was consistent feedback from people, staff and relatives that there were not enough staff. From our observations and reviewing the duty rota, there were sufficient numbers of staff. However, they were not appropriately deployed and supervised which affected the quality of care people received. There were also high numbers of agency staff who were not appropriately managed. The registered manager was unable to tell us how many staff they had and how many were permanent or agency. They told us that they were using a high percentage of agency staff at approximately 45 per cent of the workforce.
• The registered manager told us that they were going to take a more robust attitude towards staff performance from now on following poor quality care provided by permanent and agency staff.
• The provider had followed procedures for safe recruitment practices. There were relevant and up to date documents including: application forms, interviews notes, references and DBS (Disclosure and Barring Service) status confirmation. The DBS checks help employers make safer recruitment decisions and help prevent the employment of staff who may be unsuitable to work with people who use care services.
• For registered nurses, there were copies of professional registration documents. Both the registered manager and provider told us they wanted to make their recruitment processes more robust to improve the calibre of the staff in the home.
• A failure to assess, monitor and mitigate risks related to the health and safety of people was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safeguarding people from abuse:
• The staff members we spoke with had undertaken adult safeguarding training within the last year. They understood the correct safeguarding procedures should they suspect abuse. They were aware that a referral to an agency, such as the local adult services safeguarding team should be made, in line with the provider's policy. One staff member said, "I would let the manager know if I thought abuse or bad care was happening".

Preventing and controlling infection:
• There was personal protective equipment available for staff to use however, we received feedback from external professionals that staff did not always wear PPE in the service. During the inspection we did observe one staff member who blew on a person's food and helped them to eat without wearing gloves or a gown to prevent transmission of infection to that person. We noted the home appeared to be clean and we did not detect significant malodours during our visit.

Environment and equipment:
• The premises were purpose built and as such did not present significant difficulties in evacuating people in the event of an emergency. We noted there were Personal Emergency Evacuation Plans (PEEP) in place in care plans which outlined how people could be removed or kept safe in the event of an emergency, such as fire and flood.
• Equipment in the home was well maintained.

Inadequate

Is the service well-led?

Our findings

Leadership and management do not assure person-centred, high quality care and a fair and open culture. People and staff told us that they liked the registered manager, for example one relative told us, "[Registered manager] is lovely, very approachable". However, people relatives and staff were not confident in the registered manager's ability to manage the service. One person told us, "She's all right. Some time ago I'd asked for something and it wasn't done. I said to her, 'Did you remember to ask someone to do it?', she said, 'Yes, but sometimes they [staff] just don't do it". The registered manager told us that the overall situation in the service was, "dismal".

Leadership and management:
• Leadership of the service was weak. There was poor communication from the top to the bottom of the organisation. This led to unsafe practice for example, the provider and registered manager were not aware of many concerns we raised during our inspection. One relative told us, "I don't think things filter through from the top" and, "Messages aren't passed around".
• We received consistently negative feedback about some members of the senior management team who were ineffective at providing a consistently safe service in the registered manager's absence. One senior staff member told us, "I don't check the emails" and did not know when the registered manager was due to return from annual leave. One person told us, "There are problems here. The [senior staff member] doesn't manage. When the manager is away, there's no direction and there's no day to day management. Sometimes, they're not even there. It all falls on the manager. A lot of people are leaving and this makes other people more likely to leave too".
• During the inspection one senior member of staff had a poor understanding of risks to people and did not recognise the importance of preventing falls and serious injuries.
• The registered manager did not delegate tasks appropriately because they told us they did not have confidence staff would complete them, they said "I'm not comfortable handing things over". This caused breaks in the continuity of the service as tasks had to wait for the registered manager to return to the service.

• Staff did not contribute to the process of handover, some staff looked unengaged and three staff members were observed to not write any information down to assist them throughout the day. Due to concerns that staff were not following care plans, this demonstrated a poor attitude to communicating about people's needs. We did not observe collaboration or teamwork in the staff team during the inspection.
• The registered manager told us that although they perceived the culture of the service was "better than it was", there was still some bullying in the service and they had experienced bullying themselves.
• The failure to have robust leadership and management was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

• There was a negative, task focused culture in the service. People told us examples where they had not been treated respectfully. We observed one staff member wiping a person's top and face without their consent and the person said, "Get off me" and the staff member apologised. A staff member was observed to approach another staff member who was supporting someone and said, "After he's been done, well take him back to his room" in front of other people. Another staff member referred to two people calling out for

help and told us, "The issue with them is he starts and then she starts". The residents in communal areas were unengaged and were largely quiet throughout the day.
• We did observe several times on the day of our inspection, that some staff appeared to need prompting to carry out their duties; there were several examples where staff were talking amongst themselves for prolonged periods in communal areas without engaging with people. There was not a calm and relaxed atmosphere in the home; staff were frequently calling across to each other over the heads of people, which gave the impression of a workplace, rather than people's home.
• The culture of the service and poor management of staff meant that people were not treated in a person-centred way with proper regard to their diverse needs.
• The failure to ensure that people were treated with dignity and respect at all times was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to monitor the service were not effective, did not drive improvement and the registered manager and provider had not identified this.
• The provider did not have sufficient oversight of the service. When asked if there had been any concerns in the service in recent months the provider told us "No". With prompting from the inspector, they told us that they were aware of concerns about the use of bedrails in the service. This interaction demonstrated that the provider did not understand the breadth and seriousness of the concerns in the service despite the service having had involvement from external agencies for several months. The provider continued to demonstrate poor insight into the concerns after the inspection.
• Audits completed since July 2018 by one senior member of staff were inconsistent, ineffective and did not look at the safety of the service despite known concerns.
• Some of the issues with medicines management identified during the inspection had not been picked up in the audit process. Where problems were identified, the action plans had not been completed.
• Senior staff told us that the provider and staff member responsible for carrying out quality assurance checks were not very visible in the service. One relative told us they did not know what the provider looked like.
• The provider and registered manager did not implement performance management appropriately to ensure staff were accountable for poor practice. The led to ongoing and deteriorating practice as staff were not held to account. One person told us, "She wants to do the best for you, but she doesn't want to upset the staff in case they leave. There's a couple leaving this week. One of them is a great guy, I'll be sad to see him leave."
• The service was highly disorganised. There were several documents that we could not access during the inspection. For example, we asked to see the provider's call bell audit to establish how quickly staff responded to calls for assistance but we were told it was not accessible at that time as the staff member who could access this information was unwell. The CCG were also told this information was unavailable when they visited on 09 October 2018 for the same reason. This demonstrated poor oversight of the registered manager who could not access information about the safety of residents. One person told us, "[Staff] say they'll be back in a minute, never to be seen again!"
• We asked the registered manager to send us an up to date training matrix but the information we received was unclear and could not be analysed. We discussed this with the registered manager but were still unable to analyse the information and were told the matrix was still in the process of being updated. Therefore, we could not be assured that sufficient numbers of staff had received training in safety related subjects.
• The registered manager confirmed that a room where care records were stored should always be locked when unattended by staff. Despite this, we found the room was unlocked throughout the day.
• We brought the above concerns to the attention of the provider and sought assurances subsequent to the inspection as to how the governance of the service would improve. Following the inspection, we received inconsistent information about whether or not a clinical lead would be brought in to support the service. This demonstrated a lack of action taken by the provider to address the concerns.

• The failure to ensure effective systems and processes were established to monitor and assess the safety and quality of the service, drive improvement and maintain records securely was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Continuous learning and improving care:
• The registered manager had not received appropriate support within their role. They had only received one supervision session in June 2017 that had not been delivered by their line manager. They had not received any formal support since being registered with the Commission. The registered manager expressed regret when they told us they did not have someone who could be a "sounding board" to discuss clinical concerns. One staff member confirmed, "I don't think she gets the support she requires".
• People knew who the registered manager was and found her approachable. However, people told us their concerns were not acted upon. One person told us, "I've put on the form 'This and that is rubbish.' No one asked me why I said that". Another person told us "they take very little notice".
• Relatives were not always informed about changes in the care of their loved ones. One relative told us, "I find I have to ask absolutely everything, there's no sharing of information".
• We found that the service had not responded to complaints appropriately. Complaints demonstrated no clear analysis, no outcome and a lack of communication with the person who had raised the complaint. It was unclear if complaints were being appropriately recorded as there had not been any complaints since May 2018.
• The failure to act on feedback for the purposes of continually evaluating and improving the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Working in partnership with others

• There was poor partnership working with other services or bodies. Along with other external agencies, we regularly had to repeatedly ask the provider and registered manager for information. For example, there was a significant delay in safeguarding information being received by the local authority. This occurred because the registered manager had delegated the task but it had not been completed.
• The service did not have any links with local organisations or external bodies for the development of the service. This had a negative impact on the registered manager who had no clinical or managerial support.
• The failure to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that people were treated with dignity and respect at all times.

The enforcement action we took:

We used our enforcement powers to cancel the providers registration. People were consulted and moved to alternative accommodation where their needs will be met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure that people were treated with dignity and respect at all times.

The enforcement action we took:

We urgently imposed conditions meaning the provider is not able to admit anyone to the service and they must carry out audits and report monthly to us.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to prevent avoidable harm or risk of harm. The provider failed to assess, monitor and mitigate risks related to the health and safety of people. The provider failed to ensure that medicines were managed safely.

The enforcement action we took:

We used our enforcement powers to cancel the providers registration. People were consulted and moved to alternative accommodation where their needs will be met.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to prevent avoidable harm or risk of harm. The provider failed to assess, monitor and mitigate risks related to the health and safety of people. The provider failed to ensure that medicines were managed safely.

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective systems and processes were established to monitor, assess and improve the safety and quality of the service, drive improvement and maintain records securely. The provider failed to act on feedback for the purposes of continually evaluating and improving the service.

The enforcement action we took:

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