Nicholas James Care Homes Ltd

Edward House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Edward House is a residential care home providing personal care to 17 people aged 65 and over at the time of the inspection. The service can support up to 22 people. The care home accommodates people in one adapted building.

People's experience of using this service and what we found
Risks to people were not always managed to keep people safe. We observed that staff were not always using appropriate techniques when supporting people to move. Risk assessments were not completed for people's individual needs such as dementia or Parkinson's Disease. This meant that staff did not always have the information they needed to support people safely, in the way they preferred.
Systems for ordering and administering medicines were not robust and records were not consistently maintained. Guidance for staff about when some medicines should be administered was not clear.
Staff reported incidents and accidents and kept records detailing what had happened. Reviews of practice following incidents were not completed consistently. This meant that safety concerns were not always effectively managed and opportunities for learning were missed.
Staff understood their responsibilities for safeguarding people and knew how to report concerns. People told us they felt safe at the home, one person said, "I want to be here, it is safe." A relative told us they felt confident that their family member was looked after well and was safe at the home. There were enough staff employed to keep people safe.

There were significant shortfalls in the way the service was led. Governance systems were not effective in identifying issues relating to staff competency and the administration of medicines identified at this inspection. There had been a failure to make improvements following the last inspection, when breaches of regulation were identified. Changes had not been made and sustained. There were persistent breaches in areas of medicine management, risk assessment and governance.

Although staff and people spoke well of the registered manager the culture at the home was not always open and positive. Some staff had not been consistently supported.

Systems for monitoring quality at the service were not robust and this meant that there was a failure to learn from mistakes and to make improvements. Audits that the registered manager had relied upon were not always accurate and this meant that some shortfalls were not known by the registered manager or the provider and had therefore not been addressed.

The registered manager had failed to identify negative experiences for people and the impact on their dignity, through poor deployment of staff, lack of competency in manual movement and shortfalls in identifying call bell failures.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update: The last rating for this service was requires improvement (published 13 December 2018). The provider completed an action plan after the last inspection to show what they would do, and by when, to improve. At this inspection the provider had met the breach of regulation 13, however, not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the management of medicines, staffing and people's care needs. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well Led only.
We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.
The overall rating for the service has changed from Requires Improvement to Inadequate. This is based on the findings at this inspection.
We have found evidence that the provider needs to make improvement. Please see the Safe and Well-Led sections of this report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Edward House on our website at www.cqc.org.uk.

Enforcement
We have identified continued breaches in relation to the management of risks and administration of medicines and the management and governance of the service at this inspection. 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.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

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 safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Edward House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
Two inspectors carried out this inspection.

Service and service type
Edward House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with eleven members of staff including the provider, registered manager, assistant

manager, senior care workers, care workers, the chef and the regional manager.
We reviewed a range of records. This included eight people's care records and multiple medication records. We looked at staff files in relation to recruitment, training and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management;
At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. Medicines were not always managed safely. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection not enough improvement had been made and the provider was still in breach of regulation 12.
• Risk assessments were not robust and there was no clear guidance for staff to follow to ensure that identified risks were mitigated.
• Some people were at risk of falls. One person's mobility risk assessment identified that they may need support to move with the use of a stand-aid hoist. There was no guidance for staff about how to use the stand-aid with this person. Our observations were that staff were not sufficiently skilled in the use of this equipment and this had a negative impact on the dignity of the person.
• Staff had received training in how to support people to move safely, including with the use of a hoist. However, we observed that staff were not always following good practice when supporting people and were using inappropriate techniques. Risk assessments and care plans were not comprehensive and lacked detailed guidance for staff. This meant that staff did not have all the information they needed and people, and the staff supporting them, were at risk of injury from poor manual movement practice.
• We observed a person sitting in a chair and two staff supporting them to stand up. The staff did not ensure that the person's legs were in the correct position before supporting them to stand. This resulted in the staff not supporting the person's weight and not using appropriate manual movement techniques.
• Risks associated with people's physical and mental health were not always assessed and there was a lack of guidance for staff in how to support people's needs. For example, some people were living with dementia. One person's care plan referenced that they could become confused due to their dementia. However, there was no personalised risk assessment or dementia care plan in place. The was no information about what might trigger their confusion or how staff should respond to support the person. Another person had Parkinson's disease but there was no personalised risk assessment or care plan to guide staff in how to support them with symptoms. This meant that staff did not have all the information they needed to care for people safely.
• People's weight was recorded regularly and some people had unplanned weight loss but actions to identify and mitigate risks were not evident. One person had lost 6kg over a 12 month period. Their nutritional assessment had been regularly reviewed but did not identify this weight loss or assess whether this was a risk for the person. The registered manager confirmed that this had not been discussed with the GP and no nutritional advice had been sought. This meant that not all risks were identified, assessed and

managed.

Using medicines safely
• People did not always receive the medicines they needed. One person needed medicine for a digestive complaint, but their prescribed medicine had not been administered for nine days. The registered manager said this was because the medicine had run out and they were waiting for a new prescription to arrive. Staff had not considered completing a risk assessment to determine the impact for the person on not receiving their prescribed medicine. The registered manager said they had contacted the GP but there was no clarity about when the medicine would be available.
• Some people were prescribed PRN or 'as required' medicines. Good practice guidance for care homes produced by the National Institute for Clinical Excellence (NICE) states that PRN medicines, that may include variable doses, should have clear guidance for staff regarding when and how to use such medicine, what the expected effect will be and the maximum dose and duration of use. We could not find this information in the care records which meant that people were at risk of not being given PRN medicines consistently and in accordance with prescribed instructions. One person was prescribed medicine to help them sleep, although there was no guidance on the combination of medicines that could be given or how often. This could have resulted in an overdose and harm to the individual.
• The system for monitoring the stock of medicines was not robust and did not include PRN medicines. This meant that the registered manager could not be assured that stock levels were consistent with administration of medicines and made it difficult to identify discrepancies.

Learning lessons when things go wrong
• There was a system for recording incidents and accidents and staff understood their responsibility to report such incidents. The registered manager had oversight of all incidents and accidents and completed a monthly analysis of incidents to identify any patterns or trends. Despite this good practice, there was a lack of learning from incidents. For example, when people had falls, risk assessments were not always reviewed to ensure that safety was improved for them and across the service. This meant that risks to people were not always mitigated.

At this inspection there were continued concerns about the management of risks and it remained that medicines were not always managed safely. This meant there was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider has confirmed that additional checks have been introduced to support staff with manual movement and that suitable checks for medicine administration are now in place.

Preventing and controlling infection
• Staff told us that rooms were regularly cleaned however we found that some areas of the home were not clean. The bed had been made in one person's room, but the bed sheet was soiled. There was a strong smell of urine on the first floor of the home.
• Staff told us that they had received training in infection control measures. They understood the importance of using personal protective equipment (PPE) such as gloves and aprons and said that these were always available to them. We observed staff using PPE during the inspection.
• Environmental risk assessments had been completed, for example there was a fire risk assessment in place and personal emergency evacuation plans had been completed for each person.

Staffing and recruitment
• People and their relatives said that there were usually enough staff on duty.

• The registered manager used a tool to determine how many staff were needed based upon the needs of people.
• The provider had robust recruitment systems in place to ensure that staff were suitable to work with people. Staff told us they had received an induction which included working with experienced staff until they felt confident in their role.

Systems and processes to safeguard people from the risk of abuse
At our last inspection the provider had not ensured that they always had lawful authority when people were being deprived of their liberty for the purpose of receiving care. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had made improvements and sought appropriate authorisation for DoLS. Staff understood their responsibilities for seeking consent and this breach of regulations had been met.
• Staff understood their responsibilities for safeguarding people and described how they would recognise abuse. One staff member said, "I have never seen or heard anyone being unkind to people, but I would report it to the manager if I did. "
• People told us they felt safe living at Edward House. One person said, "I feel very safe here and at ease with the staff."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

At our last inspection the provider had not ensured that they assessed, monitored or improved the quality and safety of the services provided, including the experience of people in receiving those services. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection improvements had not been sustained and embedded and there was a continued breach of regulations.

• Poor practice in managing risks and administering medicines had been identified at the previous inspection. We identified a continued breach of regulations at this inspection. The provider had failed to fully address the previous breaches and to make and sustain improvements.
• The registered manager had oversight of incidents and accidents. However, there was an inconsistent approach to ensure that risk assessments and care plans were reviewed following incidents. This meant that changes were not always made to ensure that all risks were identified and mitigated as far as reasonably possible.
• When people's needs changed, systems and processes had not always identified increased risks. For example, people's weight was monitored regularly but there was a lack of oversight to ensure that unplanned weight loss was identified, risk assessments and care plans were reviewed but changes were not always made to support any increased levels of need.
• The experience of people using the service was not always effectively monitored. For example, one person told us their call bell did not always work. It was found to be hanging from the wall by one wire. This shortfall had not been identified through regular environmental checks and staff had not reported that the call bell was damaged. The person said they had to bang the wall sometimes to attract staff attention. This did not support the safety or dignity of the person.
• Staff had received training in areas that the provider considered essential. This included manual movement training and medication training. However, the registered manager had not assured themselves that, following this training, all staff were competent. For example, competency checks had not been completed for all staff who administered medicines.
• The registered manager had not ensured that staff were competent in manual movement techniques and this had an impact on the safety and dignity of people who needed support to move. Staff were also at risk of injury from poor technique.

• Staff had not been trained in how to assess or write manual movement care plans, for example, to guide staff in the use of a stand-aid hoist. This meant that there was limited guidance for staff to follow.
• The registered manager had not ensured that staff had all the guidance they needed to care for people safely. For example, there was no clear guidance for staff in how to support a person who needed to use a stand-aid. No staff had received training in how to assess people's manual movement needs or how to complete a manual movement care plan. This meant that care plans contained limited guidance for staff to follow.
• The registered manager used a number of tools and audits to evaluate the quality of the service and ensure that tasks were completed. However, this information was not always accurate. For example, an action plan was submitted to CQC in January 2019 by the provider following the last inspection. This included assurances that locks on bathroom doors had been maintained to protect people's privacy. A housekeeping audit had identified that all bathroom and toilet doors had locks as required. During the inspection we observed that some bathroom and toilet doors did not have functioning locks. This did not support people's privacy and dignity and meant that the registered manager could not be assured that quality assurance processes were accurate.

Continuous learning and improving care
• Systems did not always support improvements. Audits were completed for the administration of medicines. Some shortfalls had been identified but it was not clear what actions had been taken. For example, discrepancies in stocks of some medicines had been identified but there was no robust investigation to identify why this had occurred.
• The registered manager had not ensured that deployment of staff was enough to meet the social needs of people. Our observations were that people were left sitting in the lounge for long periods with little to occupy them and staff did not have time to spend engaging with individual activities. One staff member said, "We don't take people out, their families do that." One person told us, "We can go out but only if a family member can take us."
• Reviews of care plans were recorded monthly; however, the quality of the review was not monitored. Care plans lacked detail, were not personalised and did not always reflect the care provided. For example, a person was noted to refuse personal care, but their personal hygiene risk assessment did not reflect this and there were no clear strategies in place to guide staff in how to support the person. This meant that although the records had been reviewed they had not been updated to reflect the current situation.
• The provider had invested in an electronic care record system. Staff told us that they were recording daily notes on the electronic system. However, the registered manager was not able to access all the information on the system and told us this was because it was not yet fully implemented. This meant that the registered manager did not have full oversight of records and could not be assured that people were receiving the care they needed .
• Daily records were not always accurate, for example, some-time specific medicines were recorded as being given, however the recorded time of administration was not accurate. This was because staff recorded notes on the electronic system later in the day. The registered manager could not be sure that people were always receiving their medicines as prescribed.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• Staff spoke positively about the registered manager and described them as being "friendly and approachable." They said that they would speak to them about any concerns they had. However, a number of staff described how a negative culture had developed for a time, where they felt under pressure and unreasonable scrutiny. Staff told us that they had not felt able to speak up about these feelings. The registered manager said they had not been aware of these issues until one staff member spoke to them. Staff told us that the situation was now resolved and the atmosphere had improved but this does not

indicate an open and empowering culture.
• There was inconsistent leadership in monitoring staff and ensuring a positive culture. Spot checks were undertaken at night to assure the registered manager that standards were being maintained. One spot check identified concerns that staff were not following the provider's procedures. The registered manager explained that staff had moved to a different working pattern which had resolved the issue. However there had been no further checks to determine if these issues were more widespread or indicative of a negative culture. Although the registered manager told us they were aware of continued concerns, there was a lack of clear strategy for making and embedding improvements.

There was a continued failure to assess, monitor or improve the quality and safety of the services provided, including the experience of people in receiving those services. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• People and their relatives told us that they had positive relationships with the staff. One person said, "They are all kind, lovely people. They tell me what's happening and encourage me to stay involved."
• A relative spoke highly of the support that had been provided when their relation had moved to the home. They said, "Communication was very good, and they involved us in every way."
• The provider had undertaken quality assurance questionnaires to seek the views of people and their relatives about the service. The registered manager told us, "We have spoken to everyone who lives here and their relatives to make sure that they are all happy with the service."
• The registered manager was aware of their responsibilities under the Duty of Candour.

Working in partnership with others
• Staff described positive working relationships with the GP and district nurses. One relative described how staff had been supportive when their relation moved in to the home. They spoke highly of the communication between staff and health and social care professionals to achieve a smooth transition for the person.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a continued failure to assess monitor and manage risks relating to the health safety and welfare of people. Medicines were not always managed safely.

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a continued failure to assess, monitor or improve the quality and safety of the services provided, including the experience of people in receiving those services

The enforcement action we took:

We have issued a Notice of Decision to impose a Condition on the provider's location to be assured that they have appropriate quality assurance processes in place to assure people's safety and wellbeing.