Nicholas James Care Homes Ltd

Edward House

Inspection report

86 Mill Road
Burgess Hill
West Sussex
RH15 8DZ

Tel: 01444248080
Website: www.njch.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Edward House is a residential care home providing personal care to 16 people at the time of the inspection. The service can support up to 22 older people who are living with dementia. The home was purpose built and accommodated people on two floors with a passenger lift.

People's experience of using this service and what we found
Some improvements had been made since the last inspection, including staff understanding and practice in supporting people to move around safely. However, there remained continued concerns about safety at the home. Risks to people were not always monitored and managed so that people were supported to stay safe and lessons were not always learned when things went wrong. Staff had not all been assessed as competent to administer people's medicine and some people were not receiving their medicine as prescribed. Infection control procedures were not always followed to keep people safe from risks of infection.

Risks associated with nutrition and hydration were not always monitored and managed effectively and some people received food that was not appropriate for their needs.

Inconsistent information in records meant that staff did not always have the information they needed to provide effective care. Accurate records were not maintained to support monitoring of risks and this meant that the provider could not be assured that people were always receiving safe care that was appropriate for their needs. A new electronic records system had not yet become embedded in practice. There was a continued lack of oversight and governance because some management systems remained ineffective in identifying shortfalls in practice.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. However, one person had conditions attached to a DoLS authorisation that were not consistently met.

Care was not always provided in a way that was responsive to people's needs. People were not supported to follow their interests or to engage in meaningful occupation. Some people told us they were bored and did not have enough to do. Some social activities were offered but these were not personalised to people's interests and people were not consistently supported with activities that were meaningful to them.

Staff were not aware of the Accessible Information Standard (AIS) and people were not always provided with information is a way that was responsive to their needs. Staff practice did not always support people's privacy and respect their dignity.

Staff demonstrated an understanding of safeguarding and there were enough staff to care for people safely. Recruitment systems ensured staff were suitable to work with people. Staff supported people to access health and social care services. Assessments were holistic and people were supported to plan for care and

the end of their life.

People were supported by staff who knew them well. People said staff were kind and caring. One person said, "There are some good ones here." People knew how to raise complaints and felt their concerns would be addressed.

Improvements in the management of the home were evident but were not yet embedded and sustained. Not all previous breaches had been addressed. Staff described improved leadership and were clear about their roles and responsibilities. Staff said they felt well supported and engaged with developments at the home. One staff member said, "Things are improving, the home is going in the right direction now."

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

Rating at last inspection
The last rating for this service was Inadequate (published 10 September 2019). We found continued breaches of regulation. We imposed a condition requiring the provider to send us information on a monthly basis, to show how they were monitoring the quality and safety of the service and making improvements. This condition was implemented just before this inspection. At this inspection the provider had made some improvements and the service is now rated as requires improvement.

Why we inspected
This inspection was carried out to follow up on action we told the provider to take at the last inspection.

Enforcement
We have identified breaches in relation to managing risks to people, managing medicines, providing personalised care and the management and oversight 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. The overall rating for this service is 'Requires improvement'. However, the service will remain in 'special measures'. We do this when services have been rated as 'Inadequate' in any Key Question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services 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, 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive 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 undertook this inspection.

Service and service type
Edward House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 should have 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. At the time of the inspection the service had a manager who had applied to become the registered manager.

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in an action plan after the last inspection and information we had received about how changes were being implemented. 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 seven people who used the service and one relative about their experience of the care provided. We spent time observing care being delivered throughout the day. We spoke with six members of staff including the manager, assistant manager, care workers and the chef. We spoke with the Nominated Individual, who is responsible for supervising the management of the service on behalf of the provider. We reviewed a range of records. This included seven people's care records and multiple medication records. We looked at three staff files in relation to recruitment 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. The nominated individual sent us information in response to questions we had asked at the inspection. We received feedback from a social care professional following their visit to the service which provided further information about the care provided.

Requires Improvement

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 focused inspection on 28 June 2019 this key question was rated as inadequate. At this inspection this key question has improved to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely; preventing and controlling infection

At our last inspection there had been a continued failure to assess, monitor and manage risks relating to the health, safety and welfare of people. At this inspection some improvements had been made, but medicines and risks were not always managed safely. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People were at risk from unsafe care and treatment. Some people were assessed as being at risk of falling. One person had risks associated with Parkinson's disease, but the risk assessment did not include an assessment of the risk. A falls care plan was in place to guide staff. Records showed that the person had fallen on four occasions in the last month. Each incident had been recorded and the manager had oversight of incidents and accidents. Following each fall no adjustments to the care plan were made to provide additional measures that could mitigate risks of further falls. The care plan identified that if the person had three falls or more additional monitoring should be provided, but this had not been implemented. The manager said that a referral to the falls team had been made two months previously following another fall. They were waiting to obtain professional advice but no other actions had been taken in the meantime to address the risks. This meant that the care plan was no longer effective in reducing the person's risk of falls and the person was at continuing risk of falling.
● People were not always receiving their medicines in line with the requirements of their prescriptions. One person with Parkinson's disease was prescribed medicine to be administered at specific times. This was identified within the care plan as essential for managing symptoms of Parkinson's Disease. The person was assessed as being at risk of falls and the medicine supported their mobility and needed time to take effect. The lunchtime medicine was due at 12.00, the staff member administering medicines was aware of the importance of giving these medicines on time but did not prioritise this and the person did not receive their medicine until 12:18. However, the staff member recorded that the medicine had been given on the MAR chart at 12.00. Whilst we did not identify any negative impact for the person on this occasion there was a risk that the person's symptoms would not be managed effectively, and their risk of falls could increase by not receiving their medicine on time. We asked the person if they usually received their medicine on time but they could not tell us, saying, "I don't know, I usually get them but they take a while to take effect." The lack of accurate recording meant that the provider could not be assured that medicines were always being given in line with the requirements of the prescription. Following the inspection, the provider confirmed that they had sought medical advice and whilst no harm had come to the person, they gave us assurances they

would take steps to ensure the person received their medicine on time.
● A person was prescribed medicine for diabetes. Instructions on the medicines label identified that the medicine should be taken with or just after food. The staff member who was administering the medicine was not aware of this and the medical care plan and the MAR chart did not identify this instruction. The MAR chart recorded that this medicine was given at 8am and 4pm. Staff had not been aware that they needed to ensure the person had eaten with or before they took their tablets.
● Stocks of medicines were not monitored effectively. When a tablet was administered the staff member reduced the total recorded, however they had not checked that the total was accurate. The number of tablets did not correspond with the total recorded. We checked this with the manager who agreed that the system was not robust.
● Staff were not consistently following good practice in managing infection control risks when administering medicines. For example, some people needed eye drops to be administered. Staff were observed to be wearing gloves when they administered eye drops to one person. Without changing gloves or washing their hands eye ointment was administered to another person. This meant that there was a risk of cross contamination and this practice was not in line with the provider's infection control procedures.
● Staff did not always have the necessary skills and competencies needed to care for people safely. Not all staff had been assessed as competent to administer medicines. Staff rotas showed that on three occasions during the week of the inspection staff who were allocated to work on the night shift had not been assessed as competent to administer medicines. The manager told us that staff had completed their medicine training but that their competency had not yet been assessed so they were not able to administer medicines. They explained that they were sleeping at the home during the week and would give medicines themselves if needed. However, records showed that the manager had not been assessed as competent in administering medicines either. This meant that at times there were no staff in the building who were assessed as competent to administer medicines. The provider could not be assured that medicines were always administered safely by competent staff and this put people at risk.

Systems for assessing, monitoring and managing risks to people remained ineffective. Medicines were not managed safely and lessons were not always learned when things went wrong. Not all staff followed appropriate infection control procedures when administering medicines. Staff had not all been assessed as competent to administer medicines safely. This was a continued breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Previous poor practice when supporting people to move had improved. Staff had received training and were assessed as being competent. We observed staff using appropriate manual movement techniques and care plans provided clear guidance for staff.
●Staff had access to personal protective equipment and we saw they were using this when supporting people with personal care. The home was clean and tidy and throughout.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse. Staff had received training in how to recognise abuse and demonstrated that they knew how to report concerns. One staff member said, "I would report it to the manager straight away." Records showed that appropriate referrals had been made when risks of abuse were identified. People told us they felt safe living at Edward House. One person said, "It is safe, they keep an eye on you and there's usually someone to call if you need help."

Staffing and recruitment
● There were sufficient staff to meet people's needs and new staff were recruited safely. There were enough staff on duty to support people with their needs. We observed that people did not have to wait longer than

they should expect to have their needs met. People told us that staff responded to their needs in a reasonable time. "One person said, "They usually come quickly if you need them." Staff told us that staffing levels had improved since the last inspection. One staff member said, "Having more staff on the shift gives us more flexibility and the manager helps out too." Another staff member said, "We were short of staff before but now we have enough."

● The manager told us that recruitment had been taking place to ensure that there were enough staff. Staff were consistently recruited through an effective recruitment process that ensured they were safe to work with people. Appropriate checks had been completed prior to staff starting work which included checks through the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with vulnerable people. The provider had obtained proof of identity, employment references and employment histories. We saw evidence that staff had been interviewed following the submission of a completed application form to assess their suitability for the role.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last comprehensive inspection on 5 November 2018 this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Supporting people to eat and drink enough to maintain a balanced diet;

● People told us they enjoyed the food they were offered at Edward House. One person said, "The food is always nice, it's all home cooking here." Despite these positive comments, people's nutrition and hydration needs were not always met. One person had been assessed as needing a modified diet, because they were at risk of choking. A Speech and Language Therapist (SALT) assessment identified that International Dysphagia Diet Standardisation Initiative (IDDSI) level 6, soft and bite sized diet was recommended. The eating and drinking care plan identified that the person needed a soft diet but did not provide guidance about what this meant or any foods that should be avoided. Staff did not demonstrate a clear understanding of the requirements of an IDDSI level 6 diet and did not know that some foods needed to be avoided. Staff had not received training in modified diets. The chef told us that there were no foods that needed to be avoided as long as they were soft. This was not in line with guidance for and IDDSI level 6 diet. The chef said that they ensured that if the person had a sandwich the crusts were removed. We observed that the person had been given a beef sandwich with crisps for their evening meal. The sandwich was not cut into bite sized pieces, it had not been softened and the crust had not been removed. This was not in line with guidance for the IDDSI level 6 diet and put the person at risk of choking.

● There was a system to record the meal choices that people made. This included details of people's likes, dislikes and risks associated with eating and drinking. There was no information about the need for a modified diet for the person who needed this. Food options included a number of choices that were not recommended for people who required an IDDSI level 6 diet. When we spoke with the person and a visiting relative, they told us that they were now on a "normal diet" and received the same food as everyone else, including sandwiches, toast and roast dinners. We spoke to the manager and the deputy manager about our concerns. Neither had been aware of the requirements of the level 6 modified diet that this person needed. This meant that the person was at risk of receiving food that was not suitable for their needs and put them at risk of choking.

● A dietician had assessed the person as needing additional calories due to unplanned weight loss. They recommended that their meals should be fortified with additional calories and extra high calorie drinks and snacks should be offered every day and in line with SALT guidance. The eating and drinking care plan identified that the person required additional calories. Staff were not keeping accurate records of what the person had eaten or when. This meant that the manager could not be assured that the person had been receiving a fortified diet with additional calories or that SALT guidance had been followed. Due to our concerns we raised a safeguarding alert with the local authority. Following the inspection, the nominated individual informed us that action had been taken and information was provided to the local authority about how these risks were being managed.

● Another person had been identified as being at risk of malnutrition. A Malnutrition Screening Tool (MUST) had been completed and identified they were at high risk. The eating and drinking care plan reflected these risks and guided staff to record the person's weight every month, record their intake and encourage fluids. Records were not kept identifying what and how much the person had eaten. This meant that the manager could not be assured that the person's food intake was maintained. The person's weight was recorded monthly and they had been assessed as being underweight. There was no guidance for staff about what actions should be taken if the person continued to lose weight. Records showed a recent weight loss of 1 kg. There was no record of what action had been taken as a result of this unplanned weight loss. This meant that risks of malnutrition were not being effectively managed.
● A dehydration assessment had also identified risks of dehydration for this person. There was no identified daily target for fluid intake and no guidance for staff in what actions to take if the daily recommended amount was not reached. Staff told us that they were not monitoring food and fluids. Staff were recording the amount of fluids offered on the electronic system. However, this did not provide an accurate record of people's intake, and the records were not being used to monitor whether people were receiving the recommend daily amount. All the fluid records showed that less than the recommended daily amount was offered to people. The manager said these records were not reliable because staff were still getting used to a new computer system. This did not provide assurance that risks of dehydration were being effectively managed.
● Another person had an unplanned weight loss of 8.3kg in 8 months but there was no record of what actions had been taken as a result of this and there was no record of a referral to a dietician for support. The eating and drinking plan guided staff to ensure a plate guard was in place and to support the person by cutting up their food. We observed that the plate guard was being used however only some of the meal had been cut up and large chips were left whole. Staff did not appear to notice that the person was struggling to manage their food. This meant that the person was not receiving the support they needed to eat their food and risks associated with malnutrition were not being effectively managed.

The failure to manage risks associated with eating and drinking was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● Assessments were holistic and took account of people's diverse needs including their physical and mental health and their social needs. Assessments were reviewed and updated regularly and when people's needs changed. People's oral health needs had been assessed and care plans included guidance on the support people needed to maintain oral hygiene.
● Nationally recognised tools were in place to assess people's needs but were not completed consistently. Some people who were at risk of malnutrition did not have MUST assessments in place to identify the level of risk. People who were identified as being at risk of dehydration did not have a daily intake target calculated to inform staff of the amount of fluids that the person needed. This meant that staff could not easily assess if the person had received the fluids they needed. Failing to use assessment tools consistently meant that the provider could not be assured that staff had all the information they needed to meet people's needs. This was an area of practice that needed improvement.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● The provider was not consistently meeting the requirements of the law and guidance. Where appropriate the provider had completed DoLS applications. One person had conditions attached to their DoLS authorisation that had been met by the provider. However, another person had conditions attached to their DoLS authorisation that required the provider to ensure the person was kept busy with meaningful activities and to have outings into the local community. The social activity and engagement record for this person showed engagement with activities on ten occasions in the two months prior to the inspection. There was no record of the person having been offered the opportunity for any outings in the local community. We observed that the person was not engaged with art and craft activities that were on offer and that they were watching the television with other people in the lounge and dining area all day. We asked them about how they spent their time and whether there were opportunities to go out. They told us, "There's nothing to do. I just sit here and talk to my friends." This meant that the conditions on the authorisation for this person were not being met. This is an area of practice in need of improvement.
● Staff understood their responsibilities to comply with the MCA and described how they sought consent from people before providing care or support. We observed staff checking with people and waiting for their response before providing care. Records showed that where people lacked capacity to make specific decisions, a best interest decision had been made with the involvement of relevant people and professionals.

Adapting service, design, decoration to meet people's needs
● Decoration and design did not promote people's independence. There was some dementia friendly signage, but not all signage and decoration supported people who were living with dementia to orientate themselves around the home. One person was observed walking up and down the corridor and told us "I don't know where I am." A member of staff supported them to come into the lounge.

We recommend that the provider finds out more, based on current best practice, about how decoration and signage can help people with dementia to orientate themselves.

● People had been encouraged to personalise their rooms and told us that there was a homely atmosphere at Edward House. There was a large communal lounge and dining area and another smaller lounge. People chose where to spend their time and some people preferred to spend time in their rooms or in the quiet smaller lounge area.

Staff support: induction, training, skills and experience
● Staff were receiving the training and support they needed. At the last inspection on 28 June 2019 staff had not received the training and support they needed to support people to move safely. The provider had addressed these shortfalls and staff had received training and been assessed as competent in manual movement techniques. Staff told us they had received the training and support they needed. One staff member said, "We have a lot of on-line training, it takes time, I have completed four courses recently." Staff received training that was appropriate for the needs of the people they were supporting, including awareness of dementia and Parkinson's disease.
●Records confirmed that staff were receiving supervision. Supervision is a mechanism for supporting and managing staff. It can be formal or informal but usually involves a meeting where training and support

needs are identified. It can also be an opportunity to raise any concerns and discuss practice issues.
● Staff said that new staff received a thorough induction when they started working at the home. Some staff were employed by an agency but worked at the home on a regular basis. The manager explained that agency staff were also provided with an induction when they started at the home.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff were working with other agencies and supported people to access the health care services they needed. Staff described positive relationships with health and social care professionals. One staff member told us, "We have regular contact with the Parkinson's nurse." Records confirmed that staff sought advice from appropriate health and social care professionals when needed, including the GP, district nurse and social workers.
● People and their relatives said that they were supported to access health care services when they needed them. One relative told us they felt staff looked after people well and that staff had recognised when their relation became unwell and called an ambulance.
● Records showed that people were supported with regular appointments to maintain their health including with the dentist, optician and chiropodist.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last comprehensive inspection on 5 November 2018 this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

● People were not always treated with dignity and respect. Staff told us how they supported people to maintain their dignity when providing personal care. We observed that most staff were kind and caring in their approach. However, some staff did not always protect people's privacy when supporting them. Staff administered medicines, including applying eye drops and eye ointment to people at the meal table in front of others. Staff members did not check if people were comfortable for this to happen in front of other people or offer them the opportunity to go somewhere more private. This practice did not support people's privacy.

● Staff did not always notice when people needed help at meal time. We observed one person was picking up food with their hands because they were not able to cut up the food themselves. This did not support the person's dignity. We observed staff cleaning in the lounge area. They cleaned where a person was sitting in an arm chair. They did not speak to the person or support them to move but instead cleaned around them, placing a wet floor warning sign directly in front of them. This did not support the person's dignity. Protecting people's dignity and supporting their privacy is an area of practice that needs improvement.

● Staff told us how they supported people to remain independent by encouraging them to do what they could for themselves. We observed a staff member encouraging one person to put cutlery away following the lunchtime meal.

● People's personal information was kept securely, and staff were aware of the importance of maintaining confidentiality.

Supporting people to express their views and be involved in making decisions about their care

● People were supported to be involved in decisions and to express their views. People and their relatives told us they had been involved in making decision about their care. One person told us, "Yes, we are involved, and I think we are treated well." A relative told us they had been involved with decisions about their relation's care. They gave an example and explained how staff had involved them both in making a decision. Care plans included people's preferences, views and wishes.

Ensuring people are well treated and supported; respecting equality and diversity

● People were well treated by staff who knew them well and respected their differences. People said that staff were kind and caring. One person said, "There are some good ones here." A relative told us they had confidence that staff were kind saying, "I know when I go they are being well looked after."

● Staff knew people well and spoke about them with compassion. One staff member said, "I know everyone's story, we all know them so well."

● One staff member told us about a person's cultural needs and described their background and the

importance of maintaining family links. They explained, "When they get to speak to their family in their own language it makes a big difference. They are very happy."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last comprehensive inspection on 5 November 2018 this key question was rated as requires improvement. At this inspection this key question remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Meeting people's communication needs

● People had holistic care plans and had been involved in developing them. Their needs, including needs associated with protected characteristics, their choices and preferences had been considered. Care plans were kept electronically. The manager said that people could access the electronic documents on an electronic pad but were choosing not to do so. They explained that people could have a copy of their care plan if they wished. Staff were updating care plans on a regular basis, but people were not always involved in this process. The manager said that if people lacked capacity their relatives or social workers were consulted when care plans were reviewed and updated. One relative confirmed that they had been involved in reviewing a care plan and health and social care professional's advice was evident within records.

●Care was not always delivered in a personalised way. For example, people were living with various stages and types of dementia. Care was not always provided in a way that was responsive to their needs. During the morning, staff were observed discussing menu choices with people for the supper time meal, the staff member read a list of options available and asked people to choose. One person was heard to ask another what they had chosen, they replied, "I don't know, I can't remember." The lunchtime menu was written on a white board and was not easy to read. There were no visual aids, photographs or menus on tables to show people the options. Staff placed food in front of people but did not remind them of their choice or tell them what was on the plate. The Social Care Institute for Excellence states, "As dementia progresses a person might have difficulty choosing or deciding on the food they want to eat. Calling out a list of options can be confusing and difficult for a person as they may not recognise what the food is from hearing the words alone."

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs had been assessed and recorded. People were not always being provided with information in a way that supported their needs. For example, one person had been identified as having a visual impairment, but consideration had not been given to providing information in an accessible format. We spoke to the manager about AIS but they were not aware of this requirement.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them;

● People were not always supported to follow their interests or to be occupied with meaningful activities.

Staff provided some organised activities and people told us they could join in if they wanted to. People's individual interests were recorded in their social life and engagement care plan. We checked to see the activities that one person had taken part in during the last month. We found that only six activities were recorded relating to group activities that were offered. None reflected the person's expressed interests.

● People told us they did not have enough to do and were bored. One person said, "Sometimes I go in the garden but generally just sit and look out of the window. No, there's nothing to do." Another person told us, "There is nothing to do, we just sit here." Our observations during the morning were that people had nothing to occupy them. There were missed opportunities for engagement with staff who were task focussed and did not spend time talking to people.

● Staff told us that they usually had time to spend with people in the afternoon but that it was rare for staff to be able to support people to go out into the community. One staff member said, "We don't really take people out, their family members do that." We observed that during the afternoon an art and craft activity was taking place and some people joined in and appeared to enjoy it. Two staff members were spending time looking at magazines and watching a TV programme with people. We observed one person helping a staff member to put cutlery away after the lunchtime meal. Staff told us that everyone living at Edward House had dementia. Although some organised activities were available there was little to occupy or stimulate people at other times.

Care was not provided in a person-centred way to meet people's needs and reflect their preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● Complaints were managed in line with the provider's policy. People knew how to complain and said that they felt comfortable to talk to staff about any concerns they had. The provider had a system for recording and monitoring complaints. When people raised complaints, these had been investigated and responded to in a timely way. Learning from one complaint had been discussed with staff at a team meeting to clarify expectations about staff response to people.

End of life care and support

●People were supported to plan for care at the end of life. The provider worked in line with the Gold Standards Framework (GSF) which is a model encouraging good practice in caring for people at the end of life. People's wishes and preferences were recorded including any specific plans or advanced directives and any cultural or religious needs. There was nobody receiving end of life care at the time of the inspection.

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 focused inspection on 28 June 2019 this key question was rated as inadequate. At this inspection this key question has remained the same. This meant there continued to be 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; Continuous learning and improving care

At the last inspection there was a 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 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We imposed a condition requiring the provider to send us information on a monthly basis, to show how they were monitoring the quality and safety of the service and making improvements. This condition was implemented just before this inspection.

- The provider sent us information identifying how they would make the required improvements. The nominated individual explained that there had been considerable focus on making improvements to address the shortfalls in manual movement techniques identified at the last inspection. Records and observations at this inspection confirmed improvements in supporting people to move around had been made and the provider had systems to assure themselves that these improvements were maintained.
- Whilst some improvements in leadership and oversight were evident there remained concerns about systems for monitoring quality and governance at the home. The nominated individual sent us a report in November 2019 detailing areas of improvement following the last inspection. This included assurances that all staff had medicine administration competency checks, and that appropriate assessments were completed for people's risks associated with dehydration. However, at this inspection we found that the provider had not completed and embedded all aspects of their improvement plan. Some changes were not sustained and shortfalls in practice that we found at this inspection had not been identified through the provider's management systems. This meant that oversight and governance of the service continued to be a concern.
- The provider had a system for monitoring incidents and accidents, but staff had not maintained an accurate record in the incident and accident log. This meant that the manager and nominated individual had not been made aware of incidents that had an impact on people's safety. Records of staff handover meetings identified that a person who was living with dementia had been able to access the fire escape on the first floor of the building. Staff had been alerted and supported the person to safety before they came to harm but the manager and nominated individual were not aware that there had been a fault with the fire door. Another handover note showed that staff had noticed unexplained bruising to one person's legs but there was no record of this being reported to the manager, or recorded on the person's record, or any health or social care professionals involvement following this incident. A third handover note identified that a person had an unwitnessed fall. This had not been recorded in the incident and accident log and the

manager was not aware of this incident. The lack of consistent monitoring of incidents meant that the provider could not be assured that people's safety was being maintained. The provider responded immediately to these risks during and after the inspection. For example, they checked that the fire escape door was secure on the day of the inspection and later confirmed that the fault with the fire escape door had been dealt with by staff on the day of the incident. The manager and nominated individual had not been aware of all incidents and accidents because records were not consistent and there was no system to provide oversight of information passed between staff during the handover process. The manager took immediate action to address this shortfall.

● Records were not always up to date, accurate and complete. Some people were having their weight monitored regularly. Staff had recorded different records of weight for the same person on the same day. This made it difficult to recognise the change in the person's weight. Where it was clear that people had unplanned weight loss there was not always a record of actions that were taken or decisions that had been made in relation to the person's care. Staff were recording when fluids were offered to people on the electronic recording system, but the records were not consistent or accurate and could not be relied upon to assess if people were receiving the fluids they needed. Although the provider had audits in place to monitor care plans and risk assessments, shortfalls in recording and failure to complete specific assessments had not been identified.

● Care plan audits had not identified that some people were not receiving care in line with their care plans. Conflicting information in a person's care plan meant that staff did not understand the nutritional needs of a person who was assessed as needing a modified diet.

●Systems for monitoring the administration of medicines had not identified shortfalls in practice including infection control risks and discrepancies in stocks of medicines. There were shortfalls in ensuring that competency assessments were complete for all staff.

● Risks to people were not always monitored and managed effectively. Failures in recording meant that the provider could not be assured that staff were always providing care in line with the provider's policy and procedures. The nominated individual told us that the provider had a policy if people fell and sustained an injury. This included seeking medical attention and increased monitoring of the person. Two people had sustained an injury to their head when they fell. One person had been admitted to hospital later in the day following a fall because their condition had deteriorated. We asked to see evidence that people had been cared for in line with the head injury policy on the three recorded occasions. There was no recording to support this, this meant that the manager and provider could not be assured that staff had acted appropriately.

● The provider had not learned from known risks that had been identified in their other locations. During the inspection we spoke with the manager and nominated individual about risks associated with people on the stairway between the ground and first floor. The provider had not reviewed their risk assessment for Edward House although similar risks had resulted in a serious incident at another of their locations. This showed that the provider had not transferred learning to make improvements across their service. Following the inspection, the provider informed us that they had fitted an additional gate at the top of the stairs to safeguard people from falls.

Failures in the governance and oversight of the service meant that there was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A new manager had been in post since August 2019 and they had submitted an application to register with CQC. They explained how they had focussed on ensuring that care plans were updated and transferred onto the provider's new electronic system. They said staff had adapted well to using the new system but that more time was needed for it to become fully embedded within practice.

● Staff told us they were clear about their roles and described improvements in leadership at the home. One staff member said, "There is a clear shift plan now so we all know what we have to do. Communication has improved, we have regular handovers and that means we are kept informed of changes."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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

● There was a positive culture at the home with improved leadership. Staff spoke positively about improvements since the new manager had joined the home. One staff member told us, "The manager is approachable and cares about the staff." They explained that a system had been introduced to ensure that staff had regular breaks saying, "When we work long shifts it can be mentally very tiring. We have a proper break now."

● Another staff member described how the culture of the home had improved saying, "There is more openness now, the atmosphere is very good compared to previously. Everyone is getting on better and it is less stressful."

● The manager and nominated individual were aware of the duty of candour and understood their responsibilities regarding this. Notifications about events that must be reported to CQC had been submitted.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● There had been improvements in engagement with staff, people and relatives at the home. A staff member described how they felt staff were encouraged to share their views. They said, "Any suggestions and we tell the manager." Staff described feeling part of a team and spoke positively about involvement in changes. One staff member told us, "Improvements are being made, things are going in the right direction now and we are involved. It will get better."

● Quality assurance surveys were sent to people's relatives and health and social care professionals to gain their views on care at the home. The manager said these had not yet been returned and evaluated but comments would be used to drive improvements.

●Staff told us that people and their relatives were involved and informed about developments at the home in residents' meetings and by staff informing people on a daily basis.

Working in partnership with others

● Staff were working in partnership with other agencies. Staff spoke positively about working relationships with the GP, district nurses and pharmacist. A staff member described working in partnership with social workers and mental health professionals to support people with distressing behaviour that could be challenging to others. A staff member said, "It has helped a lot and we all learnt new strategies."

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 9 HSCA RA Regulations 2014 Person-centred care Care was not provided in a person-centred way to meet people's needs and reflect their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems for assessing, monitoring and managing risks to people remained ineffective. Medicines were not managed safely and lessons were not always learned when things went wrong. Not all staff followed appropriate infection control procedures when administering medicines. Staff had not all been assessed as competent to administer medicines safely.There was a failure to manage risks associated with eating and drinking.

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 17 HSCA RA Regulations 2014 Good governance There were continued failures in the governance and oversight of the service.

The enforcement action we took:

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