Edenmore Care Limited

Edenmore Nursing Home

Inspection report

6-7 Hostle Park
Ilfracombe
Devon
EX34 9HW

Tel: 01271865544

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20 December 2016

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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 7 and 9 September 2016. This was the first inspection for this service, which was registered on 1 February 2016 as there is a new provider of the service. We rated the service as 'good' and found they were meeting all of the regulations.

After that inspection we received concerns relating to people not having their risks safely managed, staff using restrictive practices and people not receiving adequate food. This report only covers our findings in relation to these concerns. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Edenmore Nursing Home on our website at www.cqc.org.uk. We completed this unannounced focussed inspection on 20 December 2016. An inspection manager and inspector completed the inspection. The local authority safeguarding team were also looking into concerns raised and were arranging to discuss these with the registered manager after our visit.

Edenmore is a nursing home registered to provide care and treatment for a maximum of 47 people. Most are living with the condition of dementia. At the time of our visit 41 people were staying at the home.

The service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. Edenmore had a registered manager. The registered manager said they were planning to step down from their role and was in the process of training a new manager to take on the manager's role.

During this inspection we found people were not always protected from risks posed by another person using the service. Actions had been taken for the individual to support and monitor them. These included staff monitoring the whereabouts of the person at all times. However during our visit staff were not always aware of where the person was. Where this person was entering people's rooms, no consideration had been considered regarding putting in measures to protect these people.

People were protected from the risk of malnutrition. Risk assessment were undertaken and people were weighed regularly and actions taken when concerns were identified. There was adequate food and drink available for people.

Accident and incident forms were completed promptly by staff. An analysis of accidents at the home was completed by the registered manager each month to look at patterns and trends. There had been a high level of falls in November 2016. The registered manager demonstrated they had taken action to reduce and prevent further accidents occurring by putting in place further measures.

People's freedom was protected and restraint practices not used. People were protected by staff who were knowledgeable about the signs of abuse and knew how to report their concerns appropriately. Staff said

they were happy they could raise concerns with the registered manager and new manager and that action would be taken.

We will meet with the provider in the New Year to discuss the findings and their action plan. We will then carry out a focused inspection in the near future to check that the regulation is being met.
We identified one breach of regulation at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risks to individuals were not always identified nor actions taken to manage the risks.

Staff were aware of signs of abuse and knew how to report concerns.

Risks to people regarding malnutrition were being safely managed.

People's freedom was protected. The staff were able to raise concerns with the registered manager and confident action would be taken.

Edenmore 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 20 December 2016 and was unannounced. It was completed by an inspection manager and an inspector.

We met most of the people using the service. The majority of people at the service were living with dementia and were unable to communicate their experience of living at the home in detail. We observed the interactions and support people received throughout our visit.

During this inspection we spoke with ten staff including two nurses, care staff, a kitchen assistant, a housekeeper and the registered manager.

We looked at two people's care records on the provider's computerised care system. After the inspection we reviewed an analysis of accidents and incidents sent to us by the registered manager which we requested at the inspection.

Requires Improvement

Is the service safe?

Our findings

People were not always safe. This was because one person using the service had a cognitive impairment and was not aware of the implications of their actions. The staff had sought advice and guidance from health professionals regarding this person. This person was very active around the home. They sometimes tried to access other people's bedrooms. The management team had put in place measures to monitor this person which included one to one support for six hours a day and staff to have the person in sight at all times. Staff told us this person was on a half hour location check and they had to know where they were at all times. However during our visit this person was not always in sight of a staff member. This posed a risk to other people because records showed that the person had entered people's rooms and was involved in other incidents with people. These included pushing one person over, others being pushed around in their wheelchairs and some people were intimidated by the person which caused them to be frightened and needing to be moved from communal areas. This meant people were at an increased of a physical injury and abuse from this person. No additional measures had been considered by the staff to protect these people.

We also met a person who had had several falls. Their care plan and falls risk assessment had not been updated to show that they were at increased risk since a decline in their mobility. They also had a wound on their hand which did not have a dressing applied to protect it. The body map for this person had identified a number of areas, but not on their hand. This meant the risk to this person was not being assessed regarding falling and they might not be receiving appropriate support to protect them from further falls.

This is a breach of 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

We discussed both these concerns the registered manager. They said they had been on leave and had not been made aware of all of the concerns we identified. They said they would undertake an investigation and would speak to staff to make sure they were kept informed. They assured us that they would have an alarm placed on the main bedroom of concern as a matter of urgency. This would reduce the risk of harm to others. A community mental health nurse had visited the person on the day of the visit and they were now waiting for a specialist doctor appointment. The registered manager also explained to us different ways they were trying to support the person who presented with behaviour that was challenging to the service. They said they had never needed to use restraint with this person. The registered manager sent us details after the inspection of measures they had put in place for this person. These included a named staff member allocated to ensure they were able to see the person throughout their shift and the request for the use of an alert mat. A review of the person had also been arranged by a health professional from the funding authority to look at any other measures they felt appropriate. Staff were guided by care plans which gave them ways to divert the person. Following the inspection we requested an action plan from the registered manager setting out measures they were putting in place to protect people.

The registered manager updated the care plan of the person at risk of falls during the inspection. This increased from a moderate risk to a high risk. A dressing was applied to the open wound. Staff were very clear how to care for this person and knew they always needed two people to assist them with moving. They

had a pressure mat by their chair which alerted staff if they got up, so they could provide prompt support. The registered manager sent an alert to all staff to say the care plan had been altered.

People were protected by staff that were very knowledgeable about the signs of abuse and had a good understanding of how to keep people safe. They had received training and said they would be confident if they raised an alert, that the management at the service would take the necessary action. They were also able to tell us about external agencies they could contact if they were not satisfied with the managements actions. Staff had contacted the safeguarding team about one person's behaviour but had not given all the details of a serious incident that had occurred. Since the inspection the safeguarding team have spoken with the registered manager and agreed a protection plan to protect people living at the home from potential harm. They had not sent a notification about this incident to the Care Quality Commission (CQC) which is a regulatory requirement. The day after the inspection we received a retrospective notification regarding the incident and the actions taken from the registered manager.

Staff said they felt there were enough staff allocated to meet people's needs for the majority of the time. They said some people at the service had complex needs which were unpredictable and there were occasions when more staff might be beneficial.

We looked at the concerns raised that people were not being protected from the risk of having adequate food. We arrived at the service at 16.45 when the first part of supper had started for people who required support with their meals. There was adequate food prepared for people for the supper which consisted of two fish cakes and chips and additional sandwiches along with a selection of desserts. There was adequate stock for additional snacks in the kitchen and the weekly delivery was scheduled for the following day. Staff preparing the food confirmed that there was always enough food to meet people's needs. They said should they run out of anything they would go to the local supermarket to get what was needed.

Records showed that risk assessments were completed to assess the risks to people of malnutrition. People's weights were regularly monitored and where concerns were identified action was taken. This included contacting health professionals and following their guidance, monitoring of the person's dietary intake and offering food which was fortified, for example porridge with cream and additional snacks.

Anonymous concerns had been raised that staff were putting people at risk of not having their freedom protected and allegations made the registered manager was made aware and was not taking action. This was in relation to staff barricading a person in one area of the home against their wishes. The registered manager said no one had raised with them that someone had been barricaded in a room by staff. They agreed staff had raised general concerns about the person who needed additional support and one other incident, which they had investigated. All staff said they were happy they could raise concerns with the registered manager and new manager and that action would be taken.

Accident and incident forms were completed promptly by staff on the provider's computerised care system after each event and the actions taken. The provider required that the registered manager undertake a monthly audit of the incidents and accidents at the home. The registered manager sent us the most recent analysis. This showed that there had been a high level of falls at the service in November 2016. The registered manager said and the analysis confirmed that from 1 December 2016 to 20 December 2016 the level of falls had fallen at the home. They said this was because they had put in place alert mats for people identified at a high risk of falls. They also confirmed one person who had had numerous falls in November 2016 had moved to another placement. There had been two serious injuries at the home in 2016 which are being looked into by the coroner's office.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not doing all that was reasonably practical to mitigate risks to people. 12(1)(b)