Mr and Mrs Bradley

Edenhurst Rest Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

This inspection took place on 10 April 2018 and was unannounced. Edenhurst Rest Home 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. Edenhurst Rest Home accommodates up to 24 people in one building, the home has 22 bedrooms, two of which are intended for
two people to share. On the days of our inspection 22 people were living at the home, all of these were older people, some of whom were living with dementia.

We carried out an unannounced comprehensive inspection of this service on 10 and 18 January 2018. Breaches of legal requirements were found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. The team inspected the service against two of the five questions we ask about services: is the service safe and is it well led. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for (location's name) on our website at www.cqc.org.uk"

At the inspection in January 2018 we found people were not always adequately protected from risks associated with their care and support such as falls, or pressure ulcers. There were no formal systems in place to learn from accidents and incidents. People were not consistently protected from risks associated with the environment. Risks associated with areas such as the stairs and windows had not been adequately assessed or managed and this placed people at risk of harm. The environment and equipment used in people's care and support was not always clean. Medicines were not always stored safely, this increased the risk of error.

People were not protected from improper treatment or abuse, as action was not taken to conduct thorough and robust investigations, or to refer to the local authority safeguarding adult's team as required.

There was a lack of formal audit and quality assurance systems and those in place were not effective. This meant risks to people's health and safety were not always identified or addressed.

Following our inspection we issued warning notices to the service against regulations 12, 13 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to provide us with an action plan to show what they would do and by when to improve the key questions Well Led and Good to at least good.
There was a registered manager in post at the time of our inspection. 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. The registered manager who was also the provider had employed a home manager and both were available during our inspection.

At this inspection we found the provider had made the necessary improvements to ensure they were no longer in breach of the three regulations.

People were protected against the risk of abuse as the provider had processes in place to ensure any safeguarding issues were escalated and investigated appropriately. Staff had the necessary knowledge to identify any issues of concern and were aware of their roles and responsibilities in relation to keeping people safe.

The risks to people's personal safety had been appropriately assessed and measures put in place to mitigate those risks. There was regular monitoring and assessment of risks of the environment people lived in. We saw significant progress had been made to reduce risks to people at the service.

There was effective quality monitoring processes in place to highlight any shortfalls in practice and the necessary actions to improve the quality of the service had been taken.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

We found action had been taken to improve safety. People were protected from the risk of abuse as safeguarding issues were escalated and investigated appropriately.

The risks to people's personal and environmental safety were assessed and measures were in place to reduce these risks.

Is the service well-led?

Inspected but not rated

We found action had been taken by the provider and the quality of peoples' care was maintained through clear auditing process.

Edenhurst Rest 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 done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 10 and 17 January 2018 had been made. The team inspected against two of the five questions we ask about services: is the service safe and well led. This is because the service was not meeting some legal requirements.

We undertook an unannounced focused inspection of Edenhurst Rest Home on the 10 April 2018. This inspection was done to check that improvements to meet legal requirements planned by the provider, after our comprehensive inspection on the 10 and 18 January 2018, had been made. The team inspected the service against two of the five questions we ask about services: is the service well led and is it safe. This is because the service was not meeting some legal requirements.
No risks, concerns or significant improvement were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

The inspection was undertaken by one inspector and one assistant inspector. Prior to our inspection we reviewed information we held about the service. This included previous inspections and warning notices, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved with the service and commissioners who fund the care for some people who use the service.

During the visit we spoke with two people who used the service, five relatives, two members of care staff, the deputy manager, the manager and the registered manager. We looked at all or part of the care records of five people who used the service, medicines records, as well as a range of records relating to the running of the service including maintenance records and quality audits carried out by staff at the service.

Inspected but not rated

Is the service safe?

Our findings

At our previous inspection in January 2018, we found the provider was in breach of regulation 12 of the health and social care act 2008 (regulated activities) regulations 2014. Risks to people's personal and environmental health and safety were not always assessed and managed. There was a lack of care plans in place to guide staff in how to support people in a safe way. There was a lack of analysis of falls to identify trends and reduce reoccurrence and medicines were not always stored safely.

We issued a warning notice to the provider that required they become compliant with this regulation by 7 March 2018.

At this inspection we found the provider had made significant improvements in managing the risks to people's health and safety, and as a result were no longer in breach of this regulation. One person we spoke with said, "I get the support I need (from staff)." A relative we spoke with said, "They understand [relation's] needs and give [name] continuity."

However there were still further improvements to be made and sustained. For example, we looked at one person's care plan and saw they had lost 5kg in weight in the previous month. We could not find any information in the person's care plan on how this weight loss was being managed. The assessment tool used to monitor the person's weight had not been completed correctly and staff had not highlighted the person's weight loss in their nutritional care plan.

We discussed the person's care with the manager who told us the person had suffered an acute illness around this period. They explained the person had been under the care of their GP throughout that period and the GP had been monitoring the person's health. We saw evidence of this in the person's care plan of the discussions around the person's acute health needs. However, there was no indication to show the person's weight loss had been discussed with the GP. The staff had not increased the monitoring of the person's weight or their food and drink intake, and one staff member we spoke with was not aware of the significant weight loss. This lack of information in the person's care file and poor use of the person's weight assessment tool put the person at risk of not receiving the care they required.

However, the staff member we spoke with was aware that during their illness the person had a reduced appetite, but told us that following their illness the person had been eating well and enjoyed their food. They told us how they had been giving the person enriched foods, gave them support when eating and could see the person's health had improved. We asked staff to weigh the person and found their weight had increased by one kilogram.

We discussed the poor use of the assessment tool for this person and the manager accepted that staff had not used the assessment tool to affect good care for this person. However, they told us they had worked hard to introduce effective risk assessment processes since our last visit and had been working with staff to ensure they were used effectively. Our observations of the care plans we viewed showed there had been significant improvements in the way risks to people's safety were assessed. The manager had introduced

nationally recognised assessment tools and had used these tools to produce personalised care plans for the people in their care.

For example, at the last inspection we identified one person who was at risk of falls. Their care records did not reflect the risk to the person and they did not have sufficient measures in place to adequately reduce this risk. At this inspection we saw the manager had undertaken a personal and environmental risk assessment to identify and mitigate the risk of falls for this person. They had reassessed the person's bedroom and had ensured the fixtures and fittings were made safe. The person had a fireplace which while not in use was tiled and had been identified as a trip hazard. The home manager had fitted a fireguard surrounding the fireplace. There were sensor mats either side of the bed so staff could be alerted to the person's movements at night.

During our last inspection we found the provider's approach to management of risk was reactive rather than proactive. Risk assessments were either not completed or did not contain sufficient information to show if risks had been assessed and measures undertaken to reduce these risks. At this inspection we saw the manager had approached the management of risk in a proactive way. For example, we spoke to a relative whose loved one had been admitted to the service in the last few months. The person had a history of falling when at home and they had not been managing their personal care and nutritional needs prior to admission. The relative told us the home manager had undertaken an assessment of the person when they were admitted. The home manager had made a referral to the falls team to gain advice and guidance on how to support the person and as a result had implemented measures that had supported the person to remain mobile as safely as possible. The home manager had also monitored the person's weight and provided the support the person needed to assist them with eating and drinking. For example, the use of adaptive crockery. The person's relative told us the staff at the service, "got to grips," with the person's needs straight away. They said the person was brighter, well fed and safe as a result of being admitted to the service.

Staff we spoke with were also able to give examples of how they worked proactively to reduce risks to people. One member of staff told us about one person who had recently had some difficulty swallowing when eating. The person had been referred to the speech and language therapy (SALT) team who undertake assessments of people's swallowing difficulties and give guidance on suitable diets for people. The member of staff discussed the person's diet, and how they had monitored the person's food and fluid intake. A food and fluid chart was in use and had been completed to show the type of foods the person had eaten, the quantity and how well the person had tolerated their diet. As well as the SALT team the person's GP had been involved in the management of this change in the person's needs. We saw the person's care plan, this reflected the discussion we had with the staff member and contained detailed information on the management of this person's needs.

When we last visited the service we found environmental risks had not been effectively assessed to reduce risks to people living at the service. For example, we had highlighted a risk associated with people who were at risk of falls, using the stairs. During this visit we saw the provider had taken positive action to address our concerns. They had undertaken a risk assessment and had introduced measures to mitigate these risks. Coded locks had been fitted to upstairs doors leading to the stairs. This meant that people who lacked capacity around their safety could not access the stairs unattended. The staircase had a sensor alarm in place so staff were aware if someone was attempting to use the stairs. We saw people's individual risk assessments had control measures in place to support people should they want to spend time in their rooms on the first floor. These included sensor mats outside their bedroom doors to alert staff to their movements.

Other environmental risks highlighted at the last inspection had also been addressed such as the fitting of window restrictors on all windows, replacement of windows and effective cleaning schedules were in place. We also saw storage and management of medicines had improved.

At our previous inspection in January 2018, we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They had not ensured systems were in place to conduct thorough and objective investigations into allegations of abuse. When safeguarding concerns had been raised to them, the provider had not escalated these concerns to the local authority safeguarding team. During this inspection we saw the provider had taken steps to address this and were no longer in breach of this regulation.

We saw records of previous safeguarding concerns showing how the provider had worked with the local authority to ensure thorough investigations had been carried out. The recommendations from these investigations had been implemented into the practices at the service. For example, one recommendation was for the provider to ensure all staff, including the management team, underwent safeguarding training. During this inspection we saw the training record that showed the majority of staff had completed this training. We spoke with the manager who told us they had planned within the next two weeks to ensure the remaining four members of staff to undertake this training.

Another recommendation was the updating and improving of the individual care plans for people to include information on how to manage people whose behaviours may put them and others at risk. During this inspection we saw these recommendations had been implemented. People's care plans contained detailed information in relation to how to support people, for example if a person was resistive to personal care. Staff we spoke with were able to discuss the strategies we saw recorded in people's care plans and felt as a staff group they provided consistent care for people. They told us they had the time to read the care plans. We saw there were ways for staff to record people's behaviour patterns so they could look at trends and work to introduce strategies to improve support for people.

People felt safe at the service and relatives said if they had any concerns they could report it and were confident that it would be dealt with by the provider.

Staff we spoke with were clear about how to recognise signs of abuse and they were all knowledgeable on how and whom they would report any safeguarding concerns. One member of staff told us the details for the safeguarding team were in the office and they would now ensure the local authority were informed of any safeguarding incidents or concerns. They went on to say if they were ever in doubt about whether something was a safeguarding issue, they would report it just to be sure. These comments were echoed by the manager at the service. They told us of a recent event for which they had sought advice from the local authority. The provider told us they would consider any issues of concern differently now, make sure they had documented issues and seek advice so they could be sure people were protected.

Inspected but not rated

Is the service well-led?

Our findings

At our previous inspection in January 2018, we found the provider was in breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014. This was because of a lack of robust quality assurance processes to monitor a wide range of practices at the service. Including the implementation of the Mental Capacity Act 2005, the quality of care plans and other monitoring records. It also affected the environmental cleanliness and safety of the premises.

During this inspection, we found the provider had introduced systems and processes that meant there was robust monitoring of the service, and they had acted on any issues they had found during the regular monitoring of the service. As a result, they were no longer in breach of this regulation.

For example, there were cleaning schedules in place so the manager could ensure regular cleaning was undertaken. We spoke with staff who told us there was sufficient cleaning hours available to ensure the tasks were completed. The manager had introduced daily care sheets so staff could identify what care people had received. The manager also undertook a daily check of practices at the service and recorded their findings. These included checking Medicine Administration Records (MAR), temperatures on the medicine rooms, medicine and food fridge temperatures were recorded, they checked environmental cleanliness to ensure tasks were completed. They then highlighted any outstanding actions to ensure these would be completed in a timely manner. The manager also undertook a monthly audit that monitored the environmental checks carried out by the maintenance person. This included fire safety checks, equipment checks, water temperature checks and legionella testing. The manager undertook an infection control audit each month that included spot checks on staff practice in relation to handwashing and the use of personal protective equipment (PPE).

There was evidence to show the manager also audited a selection of care plans each month to ensure they had been reviewed and evaluated so the information about people's care was relevant to their needs.

At our previous inspection we found the provider had no systems in place to analyse, investigate and learn from falls, accidents or incidents across the service. During this inspection we saw they had introduced a template to assist them to investigate accidents and incidents. However there had been no accidents or incidents since they had introduced the process.

Our discussions with the provider and manager of the service showed they had a greater understanding of their roles in relation to monitoring the quality of the service. Our observations of the environment and staff practice showed the measures the management team had introduced had a positive effect on the quality of the service.