Eden House

Eden House

Inspection report

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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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

The inspection took place on the 31 October 2014. It was an unannounced inspection. We previously visited this service on 13 November 2013 and we found the service to be compliant in the areas we assessed.

Eden House is registered to provide accommodation to persons who require nursing or personal care. Nursing care however is not provided. The home specialises in supporting people who have minimal physical care needs, but who require support to live well in the community. The service can accommodate a maximum of 5 people, it is located in Filey close to amenities and with good transport links. Eden House has been owned and operated by the same family for 19 years and three of the four people who live there have been at the home for those 19 years. The fourth person has lived in the home for six years.

Mr Mark Cusick is the registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We found that two notifications regarding the circumstances around the restraint of a person had not been submitted to the Commission. The manager of the service was not aware they should have notified the Commission of these events.

One member of staff had completed training in the protection of vulnerable adults, although no-one else on the staff team had completed this training. We did not see any evidence that staff had completed training in the Mental Capacity Act 2005 (MCA) or in the Deprivation of Liberty Safeguards (DoLS). This meant that people's capacity to make specific decisions had not been evaluated and the therefore they may not have received appropriate support. This was a breach of Regulation 23 of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

People using the service were not protected from abuse because the provider had not ensured that staff were trained and aware of best practice in safeguarding vulnerable people.. People were consulted about the support they received and other healthcare professionals were included which ensured their rights were protected.

There was a friendly, relaxed atmosphere at the home. People told us they enjoyed living there. People were able to take part in activities that they enjoyed and they received support from staff if required.

People within the home were encouraged to be as independent as possible. They all had their own front door key as well as a key to their room. People went out in to the community both on their own and with support. They decided where they wanted to go on holiday and one person decided to go away on their own. It was clear that people who lived at Eden House felt it was their home and staff provided support only when it was required.

People who used the service told us they were involved in planning what happened in 'their' home. The manager told us they discussed events on a daily basis and planned future events together but they did not hold formal meetings, as they felt this was how people living in their own homes would manage. We did not see any quality audits.

Summary of findings

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

This service was safe. People who used the service told us they felt safe and were happy to discuss any concerns with the staff. One staff member we spoke with was aware of what steps they would take to protect people.

However, only one member of staff had received any recent training in the protection of vulnerable adults. This meant that not all staff were aware of bestpractice in protecting vulnerable adults.

Staff went through appropriate recruitment procedures before they started work to ensure they were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not effective. Staff had not completed relevant training to enable them to care for people effectively. Staff did receive supervision on an informal basis but, records were not kept.

There was no evidence that capacity assessments had been completed. One person had been restrained but there was no record of or evidence to show why the restraint was in the persons best interest.

People were supported to maintain a balanced diet.

We saw from people's records that other health and social care professionals had been involved in the development of people's care plans and this meant they received the support they required.

Is the service caring?

Good

This service was caring. We saw that people were treated with kindness and compassion when we observed staff interacting with people using the service. The atmosphere in the home was calm and relaxed.

People who used the service told us they were happy with the care and support they received at Eden House. They also told us that staff treated them well and respected their privacy.

Care plans identified people's needs and were reviewed each year.

Is the service responsive?

Requires Improvement

This service was not responsive. The service operated a 'universal' incentive scheme that allowed staff to limit people's access to the TV or computer. This was not always linked to a persons care plan.

People using the service led active social lives that were individual to their needs. People had their individual needs assessed and consistently met.

Summary of findings

We saw people leaving the service throughout the day to go shopping or to go socialising in the community. In addition to formal activities, people using the service were able to go to visit family and friends or receive visitors. Staff supported people in maintaining relationships with family members.

People were encouraged to express their views and concerns on a daily basis. People were involved in an incentive scheme and this did not evidence person centred planning.

Is the service well-led?

Requires Improvement 

The service was not well-led

We found that two safeguarding notifications regarding circumstances around the restraint of a person had not been submitted to the Commission. The manager of the service was not aware they should have notified the Commission of these events.

We did not see any evidence that there was a training matrix for staff. This document would allow the manager to monitor what training staff had completed and what training they needed.

There was a registered manager in post who worked alongside staff to help support people. We saw throughout the inspection that people could approach any member of staff at any time.

We saw evidence that equipment used within the house was checked in line with the requirements of health and safety standards.

Eden House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 31 October 2014 and was unannounced.

The inspection was led by two Adult Social Care inspectors. Before we visited the home we checked the information that we held about the service and the service provider, such as notifications we had received from the registered provider. No concerns had been raised. The service met the areas we assessed at their last inspection which took place on 13 November 2013.

During our inspection we observed how the staff interacted with people who used the service. We looked at how people were supported during their lunch time meal. We also reviewed the care records for the four people who lived at the home, staff training records, and records relating to the management of the service such as audits and policies. We did not receive a provider information return (PIR) prior to the inspection. The registered manager told us they did not receive the form. We arranged for another form to be sent out to the service.

We spoke with all the people who used the service. We also spoke with the registered provider and staff, who helped support the people who lived at the home.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us "I get on with all the staff here and I feel safe" and "The staff all supported us recently during a difficult time and I felt supportive of them as they had to make sure they were safe"

We saw the safeguarding policy; it was basic and included an on-call policy for senior staff to be called if there were any safeguarding incidents that happened out of office hours. We looked at staff records and saw that only one person had received up to date training in safeguarding of vulnerable adults. They had completed "Train the Trainer" safeguarding of vulnerable adults training and it was the intention they would provide the training in-house. We found no other evidence that staff had received up to date training in safeguarding of vulnerable adults. A member of staff who we spoke with said that they would report any concerns to the manager, and when presented with a scenario staff were able to describe how they would deal with it.

Risk assessments were in place for people. However during one incident a person who used the service tried to climb out of a first floor window. A risk analysis dated 29 September 2014 said that making sure upstairs windows were either restricted for opening or locked would reduce the risk. The window the person tried to climb out of was in the staff room and the room was usually kept locked as there were no restrictors on the windows. On the day of the incident the room had not been locked and this posed a risk of harm for people who lived at the home. The manager told us they now ensured this room was kept locked so that people who used the service could not access it. Staff spoken with confirmed the room now had to be kept locked.

People's medicines were obtained, stored and administered appropriately and safely. One person managed their own medication whilst another person had a planned approach to their medication. They went to the manager once a week and obtained from their main prescription enough medication for a week. They then set these tablets up in a dosette box. They signed to say they had taken their medication for a week and this was counter signed by a member of staff. The manager explained that the person wanted some control over their medication and they had agreed together this approach. We saw a risk assessment relating to the administration of medication.

One person who used the service told us, "Staff help me to take my tablets; I keep them in my room". Each person had a key to their own room so that medication and other valuables could be stored safely. Medication administration records (MARs) we looked at were completed correctly and without errors. They were checked weekly by the manager of the service. Where people had been prescribed medicines to be taken 'when required', rather than according to a schedule, we saw there were guidelines from the person's GP about the circumstances in which they were to be taken, and each instance was appropriately recorded. Where these were medicines to help people to calm down when they were agitated or upset, records showed these were used appropriately. One person told us "I get my tablets for a week and I make sure they have given me enough, once they gave me too much and I gave them a tablet back"

We saw there were enough staff on duty to provide support. There was one staff on duty at all times with other staff coming to cover times of the day when people may need an escort to go in to the community. Senior staff were also on call so that they were available in times of an emergency.

Staff were subject to appropriate vetting procedures to ensure they were suitable people to support vulnerable adults. We saw completed application forms detailing each staff member's employment history and reason for leaving previous roles in health and social care, and two written references. Each staff member also had an Enhanced Disclosure and Barring Service (DBS) check documenting that they were not barred from working with vulnerable people. However we noted that one person had started work before their DBS check had been returned. We saw that they had worked alongside another member of staff but they had not had any formal written supervision whilst they were waiting for the check to be returned.

We recommend that the service considers the Commissions guidance on staff recruitment.

Requires Improvement

Is the service effective?

Our findings

People who used the service also told us they helped with the shopping, and we saw there was a rota for kitchen duties, including the cooking and washing up. People were assisted to do their own laundry and again we saw was a rota for cleaning the communal areas. The role of staff was to support and remind people the tasks they needed to carry out. People who used the service told us "Staff are here to help us if we need it; they are not here to say do this or that". Another person told us "If we want to go out for a meal we go in to town".

There was no evidence of whether or not a capacity assessment was necessary or had been completed when restraint had to be used with a person who previously used the service. There was no evidence that an assessment or use of a best interest meeting would be used if someone's capacity to consent changed.

People were supported to make a shopping list, choose and purchase groceries, and to cook their own meals. One person told us "We plan our meals on a day to day basis deciding who is cooking and who is shopping" and "We prepare food for each other and know what we all like". We were told that breakfast was a 'help yourself' meal and people got what they wanted. One person told us they had to down for breakfast by 08:40 each morning during the week. If they weren't down by 08:40 they missed breakfast although could help themselves to a drink at any time. We discussed the routine with the manager and they told us that the person concerned needed a structured day to help maintain good health. The person involved also told us they had agreed this routine with the manager and it was only implemented between Monday to Friday. They told us could do what they wanted on a weekend. We saw that lunch was a snack meal and people came and helped prepare it and made sure everyone had something to eat and drink before they sat down. We looked at the care records and noted that no-one required a special diet. The manager told us if someone lost interest in their food or started losing/gaining weight for no reason they would seek specialist advice about their diet.

Staff records showed that staff had not received any recent training. The manager stated they did not have a training matrix to record what training people had completed and needed to refresh. Only one of the three files seen contained evidence that any recent training had been completed. A new member of staff was part way through their induction. There was no evidence that the induction training was in line with Common Induction Standards. Staff had not received training in the Mental Capacity Act 2005 (MCA) or Deprivation of Liberty Safeguarding (DoLs). This was a breach of Regulation 23 of the Health and Social Care Act 2008. You can see what action we told the provider to take at the back of the full version of the report.

Records showed that the service sought involvement of medical and healthcare professionals when necessary, and people were supported to maintain their health. Personal care and support records showed that each person who used the service was regularly supported to see the health and medical professionals they needed to, such as occupational therapists, podiatrists, massage therapists and psychiatrists and each contact was recorded on a form with details of the appointment, the outcomes and actions for staff.

Good

Is the service caring?

Our findings

Several of the people who used the service had lived in the home for more than 20 years. They were well known to the staff. Their care plans were basic and one person told us "We all get involved in reviews". During our inspection the manager organised a review meeting for one person and the person who the review was for confirmed with the social worker when and where the meeting was to be held. Another person told us "They are always asking lots of questions about us here".

People who used the service were encouraged to be independent. Staff provided support through prompts and if necessary escorted them in to the community. One person had a job, whilst others accessed the community as they wanted. One person saw that they had run out of coffee and went to the local shops for some. Another person was observed carving a gammon joint for lunch and people made each other hot drinks throughout the day. We saw one person hovering and another person told us they had a set day for doing their laundry.

We saw from records that people went out shopping, organised their own holidays and helped organise a group holiday. Observations made during the inspection were that people were encouraged and enabled to be as independent as possible.

People who used the service told us the staff always listened to them. We observed some positive interactions with staff. People who used the service approached staff easily and asked questions about their day. They had keys to their rooms and to the front door of the home, this allowed them access to the community whenever they wanted it. People who used the service told us they were treated with respect and staff always knocked on their door before entering, and treated them with dignity.

People who used the service told us they were anxious about someone coming back to the service that had recently left. One person was particularly anxious. We looked at those records and saw that during their time in the home their behaviour had been disruptive and this had impacted on people established in the home. When this was relayed to the manager they said "They were all 'problematic' at some point and we try to tell them that and explain that they should give this person a chance."

Staff told us they held informal meetings with people who used the service usually at a meal time. These were used as opportunities to discuss what was happening in the home on a daily basis. People who used the service told us they could talk to any members of staff in private if they needed to. We did not see any records to confirm this.

Requires Improvement

Is the service responsive?

Our findings

People who used the service told us "We are always being asked questions about what we want to do" and "I have spoken to my care manager about my review." They went on to say "Staff ask me lots of questions and I tell then what I want to do and they write my care plan." Another person who used the service listened to this conversation and confirmed what we had been told. One person said "I look after myself most of the time, that's the way it works" and "The authorities see this place as a residential care home but to us this is our home."

Another person who used the service told us "I deal with my own money and pay my fees by cheque and draw my own money. I used to overspend but they (Staff) set up a money management system for me. This has helped me and I don't over spend any more." During our inspection they paid their fees. The registered manager also gave the person their own mail.

One person told us they enjoyed photography, painting and using their computer. Another person went horse riding and swimming. People told us that they went out in to the community with a member of staff. We also saw that they all visited a Friday night club, and generally organised their own days out and trips in to town. One person told us "If we want to we go out for a meal." People who used the service told us they kept in touch with their family sometimes with the assistance of the staff. One person said "Staff are here to help us if we need it".

We saw from records that one person had a job in a kitchen at a local farm shop. They told us "I make pastry. I might do finger foods for kids because I've got good at things now. I'm really enjoying it up there."

The manager told us the care plans were reviewed annually. Staff told us they monitored the plans on a daily basis and discussed with each person how their day had been.

One person told us about the 'incentive' system. They told us that each day they made records in their own journals about how their day had been. They outlined behaviours that were or were not acceptable and explained those behaviours. Staff looked at these journals and made comment in them each day and awarded a coloured star according to how they saw the behaviour. Each different coloured star had a points value. Staff spoken with told us that these records were people's own personal and private thoughts even though they were 'marked' each day. They also added comments to the diaries. We saw these diaries and found the tone of some of the comments to be unacceptable. People were 'told off' for their behaviours and sanctions had been made preventing them from accessing their TV or the computer. Comments were made in capital letters, underlined and at no time offered any structure or support to the person to help them with their behaviours.

Staff told us that people had wanted the points system because if a person got 21 points in a week they went for a 'treat' meal and if they didn't get 21 points then they had to cook their own tea. The incentive programme operated Monday to Friday and people had the weekends off. All the people who used the service were part of the incentive programme. This meant this was a universal approach to managing people's behaviours and this did not promote person centred care. We recommend that the service works with local services to ensure any incentive scheme is individualised and meets best practice.

People who used the service told us they would talk to the staff if they were unhappy about anything. If they had a complaint they would tell one of the senior managers. We saw the complaints policy and staff and people who used the service told us they knew what action to take if they wanted to make a complaint. There had been no complaints in the previous 12 months. The registered manager told us that people often had concerns but they found if they took time to talk to people about them they were usually resolved. We saw that these discussions had been recorded in the persons daily records.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager in place. We found that two incidents of restraint had occurred and that no safe guarding notifications had been submitted to the Care Quality Commission (CQC) as required.

We looked at records for the people who currently lived at Eden House and the record for one person who had recently left the service. We saw that on two occasions one person had been restrained. We did not see any evidence that restraint, when it might be necessary, was part of the care plan and the circumstances around the restraint required a safeguarding notification to be made to CQC. The manager told us that only they and the registered manager had used restraint and they had completed training in non abusive psychological and physical intervention (NAPPI). We saw evidence to support this. The two incidents had not been reported to the Commission.

The registered manager sent the relevant notifications to the Commission during our visit.

Documentation which related to the management of the service required improvement. For example, there was no training matrix in place and there was no evidence that any quality audits had been carried out. This meant that there was no monitoring of the systems in place to keep people safe.

The registered manager told us they did not have any formal meetings for staff or people who used the service. They explained that with only four people living in the home there were opportunities on a daily basis to speak to each person about their day and to see if they had concerns. If there was a group discussion we were told this took place at a meal time.

All the people we spoke with said there was a good atmosphere in the home. For example one person told us, “I love living here. I get on with all the staff they are great.” All those asked knew who the registered manager was and said they saw them nearly every day.

From our observations people seemed relaxed and had a good rapport with staff. People told us that they could approach anyone of the senior management team or staff if they needed support.

Both management and staff told us that the home had an open door policy for addressing concerns. The registered manager also worked regular shifts as a support worker and this enabled them to maintain an insight in to how people were managing.

We found the management operated an on call system to enable staff to seek advice in an emergency. We looked at care documentation which showed this system had been followed to ensure a behavioural problem was effectively managed. This showed leadership advice was present 24 hours a day to manage and address any concerns raised.

Staff received informal support in their role on a daily basis. They told us that the registered manager and other senior staff were supportive and operated an open door policy. People did not see the need for supervision given the service was so small.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Suitable arrangements were not in place to ensure staff were appropriately supported in relation to their responsibilities to enable them to deliver care to an appropriate standard. Regulation 23 (1)