New Outlook Housing Association Limited

Edenwood

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

Summary of findings

Overall summary

We inspected this service on 12 and 16 April 2018. The first day of our inspection was unannounced. This was the first ratings inspection of this service.

The service is delivered from a three storey home in a residential area of Birmingham. It provides accommodation and personal care for up to 10 people who may have learning disabilities or autistic spectrum disorder, a physical disability or a sensory impairment. Ten people were living at the home on the day of our inspection.

There was a registered manager in post at the service. 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.

Staff were aware of the safeguarding procedures and knew what action to take to protect people should they have any concerns. However, there were gaps in risk management plans to ensure staff had the knowledge to manage risks to people health and wellbeing consistently and safely. Where people's needs had changed, the records had not been updated to reflect this. Staff were not always aware of risks to people's health, but supported people to attend appointments with other health professionals when a need was identified. People received their prescribed medicines.

The provider checked staff were suitable to support people before they began working in the home and completed an induction to ensure they understood their role and responsibilities. There was a training programme to refresh staff knowledge and ensure they continued to work in accordance with best practice. However, staff required further training specific to the needs of people who lived in the home. Staff did not have regular opportunities to discuss their personal development, but felt able to approach the management team at any time with any issues or concerns.

Mental capacity assessments had not always been conducted in order to determine capacity levels prior to decisions being made. People's involvement in decision making had not been consistently recorded, although we were told people were involved in making decisions about their care. Care plans did not promote person centred care and there were no plans to enable people to achieve their maximum potential. However, staff had considered ways of making day to day information accessible to people.

Staffing levels meant there were times of the day when staff were very busy and had limited opportunities to respond to people's social and emotional needs. However, when staff did interact with people, we saw it was caring. Staff sat with people when they needed to talk with them and asked people how they were feeling.

The home was clean and tidy but the environment was not fully supportive of people with a sensory

impairment.

Systems to monitor the quality of care to people were not consistently effective. The provider had not always followed the latest regulations in line with the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. People's capacity to make decisions had not been assessed. The governance of the home was not always effective and needed improvement.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 consistently safe.

Staff did not have the information they needed to manage risks to people's health and wellbeing. There was a lack of knowledge about the risks associated with some health conditions. Staff understood their safeguarding responsibilities and the provider's recruitment process checked staff were suitable to work with people in a care environment. Staff levels met people's basic but there were not always enough staff available to respond to people's emotional and social needs. People received their prescribed medicines, but some of the processes to support safe medicine administration needed to be improved.

Is the service effective?

Requires Improvement

The service was not always effective.

There were no records to demonstrate how capacity was assessed or how the decision had been reached that a person lacked the capacity to make a decision. However, staff worked within the principles of the Mental Capacity Act 2005 and offered people choices and sought consent before providing care. Staff had the knowledge to meet people's basic needs, but needed more training to support specific health issues. People were supported to eat and drink enough to maintain their health and referred to other healthcare professionals when a need was identified. The environment was not fully supportive of the sensory needs of people who lived in the home.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were caring. They knew people as individuals and understood what was important to them. People's dignity was considered by staff who were aware of people's cultural and religious beliefs. However, there were times when staff were busy and had little time to spend with people and encourage their independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There were significant gaps in care plans and where people's needs had changed, the records had not been updated to reflect this. There was a lack of information in care plans to promote person centred care and enable people to achieve personal goals. Some people were supported to pursue hobbies and interests, but people's social and emotional needs were not always met. People felt confident to raise concerns with the staff who supported them.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Effective systems were not in place to enable the provider to identify where quality and/or safety were being compromised so they could respond appropriately without delay. Staff spoke positively about the support of the management team, but managers did not always have the time to oversee the quality of care provided within the home.

Edenwood

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.

The inspection visit took place on 12 April 2018 and was unannounced. The inspection was undertaken by one inspector. As the registered manager was unavailable to speak with us, we told the provider we would return on 16 April 2018. The second inspection visit was undertaken by one inspector and an assistant inspector.

Prior to our inspection visit we reviewed all the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the provider had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority.

Before the inspection visit, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR had been completed and gave detailed information about the service.

During our visit we spoke with three people about what it was like to live at the home. We spoke with four staff about what it was like to work at the home. We spoke with the registered manager, the team leader and the provider's quality co-ordinator about their management of the service. Following our visit we spoke with two relatives by telephone to gather their views of the service provided.

We observed care and support being delivered in communal areas. We reviewed four people's care plans to see how care and treatment was planned and looked at a selection of medicine administration records.

We checked whether staff were recruited safely, and trained to deliver care and support appropriate to each

person's needs. We reviewed the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

We looked at the risk management plans which had been written to ensure staff had the knowledge to manage risks to people's health and wellbeing consistently and safely. We found gaps in the information recorded in these plans. For example, one person used a wheelchair in the home. There was no manual handling plan to direct staff how this person should be assisted to transfer in and out of the chair safely. We asked a staff member who told us, "Two members of staff support them to get into their wheelchair. Two members of staff walk with them to support them because they can fall." However, another member of staff told us, "It depends on the staff, I can do them on my own." This meant staff did not have a consistent approach to ensuring the person's safety. This person was able to mobilise in their wheelchair chair independently. There was no guidance for staff as to how this should be managed safely, taking into account the sight impairment of everyone who lived in the home.

We found for one person, the information in their care record was at odds with what happened in practice and there were no risk management plans at all. This person's care plan stated: "I do not access the community unsupported as I am vulnerable and blind. I need staff to support me in unfamiliar places." However, we were told the person was able to go out independently. We asked a member of staff how the risks to this person going out alone were managed. They responded, "[Person] has a mobile phone they will always use. We ask them to phone and let us know they are safe and when they are coming home." However, at the time of our visit the person's phone was broken and no plans had been implemented to manage the risks to this person's safety until the phone had been repaired. There was no contingency plan to advise staff what action to take, and after what period of time, should the person fail to return home.

Another person had locked themselves in their bedroom on two separate occasions, resulting in staff having to take action to access the room. There was no plan to inform staff how to manage this risk if it should happen again in the future.

Another person smoked. The assessment by their social worker stated the person, "Has a long history of unsafe smoking habits" and, "They need to be supervised at all times when smoking." There was no risk assessment in place to support this person to smoke safely. We were told staff kept the person's cigarettes and lighter and accompanied them at all times when they were smoking. During our visit we saw a time when the person was left outside smoking, and a staff member did not remain with them.

We found staff were not always aware of risks to people's health. For example, two staff were not aware one person had epilepsy, even though there was an epilepsy protocol in their care plan. One staff member was unaware that a person who lived in the home was diabetic and said, "I don't think there is anyone with diabetes here." Another staff member knew the person had diabetes, but was not aware of them having a special diet. A third staff member told us, "[Person] has diabetes. It is diet controlled." We asked whether this person had been supported to monitor their blood sugar levels and were told, "You would have to ask their key worker about that." We asked the person's keyworker who confirmed a blood test had recently been carried out, but was unable to confirm how frequently the tests should occur. There was a lack of knowledge about the condition and the associated risks.

Accidents and incidents were recorded by staff and monitored and analysed by the provider to ensure appropriate action had been taken to minimise any identified risks and identify any trends or patterns. Staff also recorded any marks or bruises to people on body maps, although it was not always clear what action had been taken. For example, one person had a body map for a bruise to their body. On the body map a member of staff had recorded 'no idea how done'. There were no records to evidence this had been investigated to identify a potential cause or whether it needed to be reported as a safeguarding concern.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

People told us they felt safe in the home. One person told us, "I feel confident here." Relatives also felt assured their family members were well looked after. One relative told us, "[Person] is definitely safe there. I never have any worries."

Staff had received training so they understood what might constitute abuse and the action they should take to safeguard people if they had any concerns. One staff member commented, "You are looking after people who are vulnerable. They are open to abuse in many ways." Another described abuse as, "Forcing them to do something or even not looking after them." Staff told us they would be aware of the signs people who were unable to verbally express their concerns would show they were worried. "They may become agitated, they may look depressed or they could cry. I would approach them and give them comfort and I would go to my line manager." The provider and local authority's policies for safeguarding were clearly displayed in the main office to ensure staff were constantly reminded of them. The registered manager notified us when they made referrals to the local safeguarding team. They had made one notification in the 12 months prior to our visit.

Staff told us they would not hesitate to report poor practice by another staff member. One staff member said they would escalate their concerns if they felt appropriate action had not been taken. "Then I would go higher, to the chief executive. There is a whistleblowing policy so I would certainly do that if necessary."

The provider operated a recruitment process to make sure staff were suitable to work with people in a care environment. We checked three staff files. Each staff member had references and a Disclosure and Barring Service (DBS) check. The DBS is a national agency that keeps records of criminal convictions. Staff told us they had to wait for all the checks to be completed, before they could work independently with people.

The level of care and amount of staff in the home was dependent on, and agreed with the commissioners. We were told there were four care staff in the morning, three in the afternoon and two waking members of staff at night. Permanent staff covered planned absence, and agency staff were used to cover unexpected absence.

However, during our inspection visits we saw six or seven people sitting in the lounge for prolonged periods without a staff presence. Staff felt there were enough staff to keep people safe, but found it more of a challenge to respond to people's emotional and social needs. One staff member explained, "I think we are alright with the numbers we are on. If one person wants to go out, we have to take two or three others with us. Sometimes it is a struggle to get people out." Another staff member told us, "I think we need more staff. I can cope on my own due to my experience, but others could struggle."

The registered manager told us each person had been assessed as requiring the same number of hours care despite them having very different support needs. They explained this impacted on people when they wanted to engage in social activities or attend appointments outside the home. "Everybody needs one to

one support to go out. Two people have gone out today so that leaves two staff for the rest. It can be quite restrictive if people want to go out." The registered manager had identified that one person now needed one to one support because of their mobility needs. This had been referred to the person's social worker and they were awaiting the outcome of an assessment. This person's care plan stated "I require 121 support at all times due to mobility", but we saw times when the person was left in the lounge with other people with no staff presence. The registered manager felt that once one to one support had been agreed for this person, it would mean the person was safer and staff would have more time for the other people who lived in the home.

Overall, medicines were managed and administered safely, and in accordance with people's prescriptions. Medicines were stored in a locked cupboard in a locked medicine room in line with the manufacturer's instructions. We noted the temperature of the medicines cabinet was consistently between 23 and 25 degrees centigrade, with most medicines required to be kept below 25 degrees. The team leader acknowledged they would need to take action to ensure the temperature was not exceeded during the warmer months.

Most medicines were delivered in 'bio-dose' packs with all the medicines that should be administered at the same time of day in pre-packed pots for each individual person. Medicines that had a short shelf life once opened, had the date of opening recorded on them. Only trained and competent staff administered medicines.

Staff recorded when medicines were administered on individual medicines administration records (MAR). A second member of staff observed the first and witnessed their signature, which minimised the risk of errors. The MAR sheets we reviewed showed medicines were signed for as 'administered' in accordance with people's prescriptions. Staff used body maps to record when and where they applied prescribed creams. Medicines not in the bio-dose pots were checked daily so any discrepancies or errors could be quickly identified.

However, we found that when handwritten amendments were made to the MAR these were not signed by the member of staff making them or by a second member of staff to confirm their accuracy. The administration instructions for one person's medicine was that it should be given 30 minutes before other medicines. However, this medicine was in the same bio-dose pot as the person's other medicines which meant they were taken at the same time. The team leader said they would discuss this with the pharmacist.

Some people were on 'as required' medicines for mild pain or anxiety and agitation. One person's guidelines said their medicine should be administered 'if I show signs of severe agitation or anxiety'. There was no information about how these signs might be demonstrated and there was no supporting care plan for these behaviours to say how staff could divert the person without the need to resort to medication. This meant the medicine may not be given consistently by all staff and may be given when not required. Another person was given a medicine if 'I show signs of severe agitation and if de-escalation strategies haven't worked'. There was no guidance about what the de-escalation strategies were and what severe agitation looked like.

The home appeared clean and tidy. Care staff were responsible for tidying the home on a daily basis and a member of domestic staff worked three days a week and completed 'deep cleans' of people's bedrooms and en-suite bathrooms. Night staff had cleaning schedules for the kitchen and communal bathroom.

The provider had a continuity plan in the event of an emergency which included emergency telephone numbers for the gas, plumber, electrician and maintenance services. The registered manager had identified the support individual people would need to exit the premises promptly in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

The 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 an assessment shows a person lacks 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. The application procedures for this in care homes are 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 were being met. We found the requirements of the Mental Capacity Act 2005 (MCA) were not consistently followed.

There was information in people's care plans about the basic everyday decisions they could make, such as what clothes they wanted to wear, what time they got up and what they had to eat. However, there was no evidence of the provider assessing people's capacity around more complex and specific decisions, such as whether they could make the decision to live at Edenwood or how they would like their medicines and finances managed. There were no records to demonstrate how capacity was assessed or how the provider had come to the conclusion that a person lacked the capacity to make a particular decision.

Where it had been decided people did not have capacity to make a decision, decisions were made in their best interests. However, records were not always maintained of how it had been decided that a decision was in a person's best interests. For example, one person had been invited to have a routine health screening. The invitation had been declined because of the person's anxiety around medical appointments. There was no record to demonstrate who had been involved in that decision, or the options discussed before the decision had been reached the person should not attend.

Two people had capacity to make their own decisions. One person smoked and we were told they had agreed that staff should look after their cigarettes and lighter and that they would only have four cigarettes a day because they were trying to reduce how much they smoked. There was no paperwork to confirm the discussion and that the person had agreed to staff controlling their access to cigarettes.

Despite the lack of records, staff supported people to make decisions when they were able to. One person with capacity had previously refused a medical procedure, but with the support of staff, had now agreed to go through with it. A staff member explained, "We just spoke about it and explained what a difference it would make to their life." Where a need was identified, people had advocates to support with decision making.

When necessary for people's safety, applications had been made to the local authority to deprive people of their liberty. Where DoLs had been authorised but conditions attached to the authorisation, the registered manager had ensured they were complied with. However, staff were not aware of people's individual restrictions because they did not know who had an authorised DoLS in place. Comments included; "Nobody

as far as I have heard" and, "I'm not sure."

Care staff worked within the principles of the MCA and asked people for consent. They asked people if they wanted to have their lunch and whether they were ready to take their medicines. One staff member explained, "They all have their own way of making their own decisions and telling us they don't like something or don't want to do something, but they just can't verbally tell us. It is their choice and we can't force them, but we can guide them." People who were able to, told us they were able to make their own everyday decisions and get up and go to bed when they wanted to.

We found that limited consideration had been given to the environment to enable people to move around the home without the supporting hand of staff. There were raised grey panels along the corridors which people could use to guide them and blue handles on the white bedroom doors, but no other use of colour, lighting or textures to enable people to know where they were in the home or support them to more around independently. One person told us, "They (staff) take me around the house, but I have to sit here until they come." When we asked one staff member if the environment supported people, they responded, "I don't think so. I think you should go the extra mile with people with a visual impairment." The registered manager told us people "possibly would be" more confident to move around the home independently if improvements were made.

When we discussed the environment with the provider's quality improvement co-ordinator they told us, "The environment has much improved. We are continuing to work around the visually impaired facilities we have around the service. There are still improvements that can be made and that is being looked at, at the moment. We are looking at the colour co-ordination, brightly coloured areas and flooring."

Staff told us they read people's care plans, had an induction to the service and worked alongside experienced staff before they worked independently with people. Staff completed the Care Certificate if they were new to care. The Care Certificate assesses staff against a specific set of standards. New staff completed a six month probation to ensure they had the right values and attitudes to work in the home.

Staff told us they completed 'mandatory' training which was 'refreshed' on an annual basis. Most training was completed via e-learning and included safeguarding people, infection control, documentation and record keeping, equality and diversity, first aid, food safety and health and safety. One staff member told us they had received training in 'autism awareness' and said, "It sort of helped to understand how they think so we understand them better. In my mind it was just a wider view of what it entails having autism."

However, we found staff had not always received training for people's specific health conditions. For example, all the people who lived in the home had a sensory impairment and some people had epilepsy or diabetes. Staff had not received training in these areas so they had the knowledge to provide consistently effective care. The registered manager agreed people would receive more effective outcomes if staff had further training in epilepsy management, key working skills, how to promote independence and sight and hearing impairment. They felt that now they had a more stable staff team, they could start providing the more specialist training staff required.

Staff told us and records demonstrated that staff did not have regular formal opportunities to discuss their training and development. Two staff told us they had not received any supervision since they completed their probation. Supervision is a meeting between the manager and member of staff to discuss the individual's work performance. One staff member explained, "I haven't had a supervision yet. If I have anything to ask or have any concerns, I will go upstairs and ask, but I haven't had that 'one to one' for them to ask how I am getting on." The provider's quality improvement co-ordinator told us, "There is an agenda

for supervisions, but they haven't been happening as often as they should."

People spoke positively about the meals provided. Comments included: "The food is lovely. You can choose your dinner" and, "The food is good." We saw people made their own choices. At lunch one person asked to have kebabs and another person asked for a sausage sandwich for their tea. People were given drinks with their meals. One person had a special diet because of their faith and this was supported by staff.

Where people needed special equipment, such as a lipped plate to help them eat independently, we saw this in place. People had different cups and glasses to support their different needs. One person had a spouted beaker, another a plastic beaker and a third a china mug. However, at lunch time there was limited opportunity for staff to engage and chat with people making it a positive sociable experience; it was a very task orientated activity. We asked the provider's quality improvement co-ordinator what they thought of the meal at lunch time. They responded, "I think it could be more of a social occasion."

People's needs were assessed before they moved to the home to ensure they could be met and there was mostly a smooth transition between services. Staff told us one person had recently moved to the home from hospital and the transition had not been managed as effectively as it should have been. For example, the person was on 'as required' medicines to support their mental health, but this had not been identified during the assessment process. During the person's first few days in the home, staff contacted the mental health team who visited and confirmed what medicines the person was on.

Staff supported people to attend appointments with other health professionals, such as doctors, psychiatrists, physiotherapists and chiropodists. A psychiatrist had recently asked staff to record information about one person's sleep patterns. Staff were completing the records as requested. Staff accompanied people to healthcare appointments, which ensured people were supported to share information about their concerns. Staff were also able to speak up on the person's behalf and offered support and reassurance if people became anxious. One staff member explained this was vital for one person because, "They would not be able to do it on their own, they need that constant reassurance they are not on their own."

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us they were happy with the support they received and that staff were caring. One person felt their emotional wellbeing had improved under the care of staff and explained, "I've come out of my shell a bit." A relative told us they knew their family member was happy at Edenwood when they started referring to it as home. They explained, "[Person] always says she is going back home. When they started saying that, I knew they had settled in."

During our visits we saw times when people were left alone in the lounge for prolonged periods of time with no staff interaction. During these times there was little to motivate or stimulate people which meant they sat with nothing to occupy them. One person told us, "They (staff) don't come into the lounge and talk to the residents. They ought to chat to the residents, and some don't do that."

Some people were encouraged to complete daily tasks around the home. One person was encouraged to help lay the table before lunch and another helped clear away after the meal. On the second day of our visit one person was helping staff to prepare lunch. However, the registered manager agreed that some people who were less physically able needed more time and encouragement from staff to promote their independence and sense of wellbeing. They told us this was an area where staff needed more confidence to enable people to achieve more independence in their everyday lives and explained, "We need to motivate staff to support people to do things for themselves."

However, when staff did interact with people, we saw it was caring. We saw staff sat with people when they needed to talk with them and staff asked people how they felt and if they were okay. People were comfortable around staff, and by their reactions, people demonstrated they enjoyed engaging with them.

We asked staff whether they thought the support provided within the home was caring. Staff told us they thought it was. One staff member told us, "I get so much out of it. It makes me smile to help somebody to live a better life because they have got support from us."

Staff demonstrated an understanding of people as individuals. For example, when we asked staff to tell us a little about each of the people who lived in the home, they focussed on people's personalities and likes and dislikes. There was information in people's care plans about how people who were unable to communicate verbally would demonstrate their emotions such as anger, sadness or boredom. One staff member explained, "My full attention has to be on the person so that I understand them."

Each person had a one page profile which set out what was important to them. For example, two people always wanted their watches with them so they were aware of the time. Staff had ensured both people had their watches to hand and we saw them referring to them at different times of the day.

People's dignity was considered by staff. People looked clean and tidy and wore clothes that reflected their own tastes and preferences. One staff member told us, "Personal care is outstanding. We are on the ball with personal care. I think the personal care aspect is really spot on here." Relatives confirmed their family

members always looked well presented. One relative said, "If they spill anything, staff go and help them change. Their clothes are always nice and clean."

Staff were aware of people's individual cultural or religious beliefs. Staff confirmed one person only ate a diet in line with their spiritual beliefs. However, this person's care plan stated there was a specific religious symbol that was very important to them and should be worn at all times. We saw the person was not wearing the symbol and when we pointed this out to a member of staff they confirmed, "They should be. Whoever did their personal care should have put that on this morning." The staff member immediately ensured this was done.

Relatives told us they could visit the home whenever they wished to and felt welcomed when they arrived. One relative particularly valued that staff kept them informed about their family member and any changes to their health.

Requires Improvement

Is the service responsive?

Our findings

Although people and their relatives felt they were appropriately supported, care planning was not responsive to people's individual needs or any changes in those needs.

People's care plans were not signed or dated so it was difficult to know when they had last been reviewed. However, significant gaps in care plans and risk assessments indicated they were not reviewed regularly. Where people's needs had changed, the records had not been updated to reflect this. For example, a detailed description of one person's daily routine did not reflect changes in their mobility which meant they now used a wheelchair in the home. Another person was able to go out independently, but their care plan still stated they should not leave the home unaccompanied by staff. Staff were meeting both people's needs despite the lack of up to date information in their care plans.

One person had moved to the home three months before our inspection visit. We were told the person had visited the home once before moving there. There was no paperwork to demonstrate the visit had been assessed to ensure the home could meet the person's needs, but also that the person fitted in with the people already living there. There was no care plan for this person which meant staff did not have any information about how they needed to support this person in a consistent way that met their individual needs. A senior member of staff acknowledged that due to the person's mental health needs, a consistent approach from staff was vital which was not supported by a lack of care planning records.

We found there was a lack of information to promote person centred care, especially when people could demonstrate behaviours associated with anxiety. For example, one person had a dislike of medical appointments. Their care plan stated two staff had to attend appointments with them because of the person's level of anxiety. There was no positive behaviour plan as to what steps staff could take to minimise the anxieties, such as booking the first appointment of the day or arranging for the person to go straight into the doctor without having to sit in the waiting room. The person's care plan also said 'can be confused and agitated – staff to comfort and offer reassurance'. There was no information to guide staff how this could be done most effectively to meet this person's individual needs. Another person's care plan stated they can be "happy" and "sad" but there was no clarification on what this meant or how staff should support the person with their emotions.

We discussed gaps in the care plans and the lack of any meaningful reviews with the registered manager. They responded, "We have got no excuse. They should all have been updated and they have not."

We found there were limited plans to enable people to achieve goals and promote their wellbeing. We were told that each month people had a meeting with their keyworker and goals were set. However, one person's goal was to go to the park weekly which was an activity they already enjoyed rather than a goal to achieve something new. The provider's quality improvement co-ordinator confirmed this was an area where improvements were required. They told us they had recently held a workshop for staff, "To promote independence and encourage people to do more".

People had support plans for 'choice and control' which indicated what support they needed to make choices. The registered manager told us that people could be provided with information in an 'easy read' format to support their decision making. Two people had talking newspapers and one person had a talking watch which meant staff had considered ways of making day to day information accessible to people.

The registered manager told us they provided each person with their home for life. They told us that while everybody was currently fit and well, they would work with people, their family and healthcare professionals to ensure they received appropriate support if they became poorly.

Some people were supported to pursue hobbies and interests outside the home. For example, some people attended cookery classes, sensory sessions and music classes. There were also some in-house activities. On the afternoon of our visit a 'music and exercise' person was in the home and after they had gone, staff continued to dance and engage with people. There had been a recent Easter party which people from the provider's other home were invited to attend, and plans were in place for similar social opportunities.

However, on both days of our visit people's social and emotional needs were not always being met. During the morning there was very little to motivate and stimulate those people who were in the lounge. There were extended periods of time when people were observed sitting with nothing to keep them occupied or promote their emotional wellbeing. One person was asleep and two others were not engaged at all. Another's person's movements indicated they felt unsettled. Staff were not able to give these people their time because they were busy in other areas of the home. There was nothing to indicate this was unusual.

One person's care plan stated they liked to go out regularly. It stated they enjoyed a walk in the park, liked to go out for meals with staff and liked to go on holiday. The person's seven day activity planner said they should go for a walk on Tuesdays, out for a meal or coffee on Thursdays and shopping on Saturday. The person's social worker had reviewed this person's care and in a report dated 16 November 2017, they had written, "[Person] needs one to one support for a daily walk.' We looked at the person's daily records. They had only been out for 'short walks' twice in 12 days. One member of staff told us, "There could be more activities. There are some but it could improve." Another said, "Sometimes I think it is not enough."

People who were able to told us they would speak to staff if they had any concerns. One relative told us they would not hesitate to raise their concerns with senior staff and felt confident it would be dealt with immediately. The provider had not received any complaints about the service in the 12 months prior to our inspection visit.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager who also managed another of the provider's homes. The registered manager was supported by a team leader who told us they had protected time each week to carry out the managerial aspects of their role. We found improvements to the management of the service were required because shortfalls we found during the inspection had not always been identified and acted upon. Effective systems were not in place to enable the provider to identify where quality and/or safety were being compromised so they could respond appropriately without delay.

Where people had risks to their health and wellbeing, risk management plans were not always in place to reduce or remove the risk. For example, there was no risk management plans to inform staff how to maintain the safety of a person who was able to leave the home unaccompanied by staff.

There was a system to record accidents and incidents, although this was not always effectively implemented. Some injuries were only recorded on body maps and we could not be sure the registered manager had considered the root cause to identify ways to prevent the injury re-occurring.

The registered manager and provider carried out some audits and checks. However, we found the systems to monitor the quality of care to people were not consistently effective. For example, care plans had not been reviewed to identify when people's needs had changed or where there were gaps in risk management plans. Care plans did not promote person centred care and there were no plans to enable people to achieve their maximum potential. This meant people did not always receive individualised care that consistently met their changing needs and promoted their independence.

The registered manager told us they were supported by the provider through supervision and regular meetings attended by other managers within the provider group. Individual managers attended external forums, workshops and provider groups and shared their learning at these meetings. The quality improvement co-ordinator told us the purpose of the meetings was, "To have an overview of the entire operation, share any learning, assess what has happened previously and reflect on any past matters."

However, we found these meetings were not always effective. When issues had been identified at inspections of other homes within the provider's organisation, learning had not been taken to improve service provision in Edenwood. For example, when we visited one of the provider's other homes in April 2017, we found decisions made on behalf of people were not always made in line with guidance and legislation and staff were not always responsive to people's social and emotional needs. Learning had not been shared because we found similar concerns at our visit at Edenwood.

This was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

The provider had confidence in the registered manager. The quality improvement co-ordinator told us, "The registered manager is working to promote individualisation and independence." They went on to say, "She

manages two services, she is very direct, compassionate and dedicated to ensuring people have good outcomes. She is a very sharing manager, very open and transparent."

However, we found the demands of managing two homes had impacted on the time the registered manager had to oversee the quality of care provided at Edenwood. One person was able to tell us who the registered manager was and explained, "She is managing two homes. She is okay, but she is working in two homes which is a lot to take on."

The registered manager was open about the challenges they faced when they took over the management of the home in May 2017, and acknowledged that improvements needed to be made. They explained that when they arrived, there had been a heavy reliance on agency staff which meant they had to concentrate on recruitment to ensure people received care from a consistent staff team. The registered manager explained they would feel more supported if the team leader could be allocated more protected time to carry out the managerial aspects of their role and ensure care plans and risks assessments were reviewed and up to date. They also felt they needed to consider the position of their office on the second floor as it meant they did not have an overview of what was happening in the home on a day to day basis. They explained, "Being up here isolates me from what is going on down there. It feels quite isolated up here."

Staff spoke positively about the registered manager. They told us that although they did not regularly have formal opportunities to discuss their professional development, they felt able to approach the registered manager with any concerns or issues. Comments included: "She is fair and friendly. I like her, she encourages you" and, "She is understanding and she is willing to help." Staff also felt confident in the support provided by the team leader. One staff member told us, "The team leader is second to none. She is always there and ready to help out." Another commented, "She is wonderful. I feel I can speak to her about anything and she will give good advice." Staff told us they enjoyed working in the home with one staff member telling us, "It is a lovely job. It is a lovely place to work. It is a nice environment."

The provider had appointed a quality improvement co-ordinator who had been in post for three months at the time of our inspection. The quality improvement co-ordinator told us part of their role was to identify areas that required improvement within the home and support the registered manager in achieving those improvements. The provider was also developing ways to motivate staff and encourage staff retention. They had recently introduced a bonus scheme and good practice was recognised through an awards scheme.

People were invited to share their views and plan their care through meetings with their keyworker and 'residents meetings'. However, the registered manager acknowledged these needed to be improved so people were empowered to provide feedback and share their experiences of the service in ways which suited their needs. They told us they hoped to be able to use these meetings as further opportunities to get people's views and improve the service as a result.

The registered manager understood their responsibilities to submit notifications to us about important events that happened at the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment Where care records evidenced a risk to the person or to others, the provider had not always assessed the risk or produced a plan for managing the risk.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's systems to monitor the quality and safety of the service were not consistently effective.